



forum

N C M E D I C A L B O A R D

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President's Message

Wayne W. VonSeggen, PA-C

Choosing the Right Words, the Right Place, and the Right Time

The Right Words

In the work of the North Carolina Medical Board, we are challenged to license and discipline and to properly regulate the practice of medicine and surgery in North Carolina for the benefit and protection of the public. In the position statements and the various motions that the Board considers and acts upon, the Board must carefully and cautiously use the appropriate words to convey the principles involved. The Board often attempts to clarify the words by defining them with great precision. Some of the

more challenging words recently addressed have been "injection," "surgery," "invasive procedure," "scope of practice," "competence," and "continuing medical education."

In the area of scope of practice, the Board accepts the fact that, more often than not, the scope of practice for a given profes-

"In North Carolina, we have recently experienced significant differences of opinion about ophthalmology and optometry scopes of practice"

sion has already been determined by the North Carolina General Assembly, and codified in statute, with regulations to clarify the remaining issues. Sometimes, the General Assembly has chosen to leave certain issues undefined, with some professions struggling to implement their own nationally promulgated and hopefully successful scope of practice. Occasionally, when new professions arrive on the health care scene, there is inevitable overlapping of skill bases. Often these can be worked out on a national basis, with individual professions hoping to stake a claim to a particular "scope of practice" by their own definition. In North Carolina, we have recently experienced significant differences

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Andrew W. Watry

From the Executive Director

Feedback

This article appears opposite a message from the Board's president, Mr Wayne VonSeggen, which, in this instance, is particularly poignant for me. His topic, choosing words carefully, covers an area to which I need to devote some attention. So, in an abundance of caution, I consulted *Merriam-Webster's Collegiate Dictionary*. The first definition of feedback is: "the return to the input of a part of the output of a machine, system, or process (as for producing changes in an electronic circuit that improve performance or in an automatic control device that provide self-corrective action)." The Board may be viewed as a control device for public protection, mandated by the public through legislation. A similar device exists in our 49 constituent states, as well as a majority of countries and other political subdivisions throughout the world.

In our jurisdiction, we pay particular attention to feedback. This is done through a variety of mechanisms. The principal mechanism is the work of the Board's Public Affairs Department, of which this publication, the *Forum*, is a major product. Another important element of that department's activity is the posting of public information for consumers and licensees both on the printed page and on our Web site. Feedback is vitally important to the Board, allowing us to identify and implement self-corrective action.

"Feedback is vitally important to the Board, allowing us to identify and implement self-corrective action"

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forum

N C M E D I C A L B O A R D

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We welcome letters to the editor addressing topics covered in the *Forum*. They will be published in edited form depending on available space. A letter should include the writer's full name, address, and telephone number.

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Choosing the Right Words

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of opinion about ophthalmology and optometry scopes of practice, primarily regarding whether an injection should or should not be considered surgery. The optometry statute specifically excludes surgery from the scope of practice of optometry. The North Carolina Medical Board continues to work toward a clearer understanding between these groups of highly skilled health care practitioners. It is a work in progress.

Conceptually, scope of practice is different from the standard of care, which more accurately describes what is currently being done in a certain locality. When the standard of care for a profession exists, can it ever change? Is the standard of care a local phenomenon? Or is it a statewide phenomenon? Or is it, finally, determined nationally? When a possible change in the standard of care for a particular profession is acknowledged, from whose perspective is that standard of care determined: the professionals who support the new standard or the average citizen-patient? Scope of practice, being

defined principally by statute, is more than a wishful expectation, it is a legal boundary that requires careful analysis of the law as well as issues such as training, experience, and public safety.

At issue is the responsibility and duty of regulatory boards themselves. How far can the regulatory board proceed with defining words, concepts, and overlapping scopes of practice while still performing the primary function of protecting the public?

"There is potential conflict ahead when one profession significantly infringes on the scope of another"

While each profession seeks to carve out its niche in the health care arena, there is potential conflict ahead when one profession significantly infringes on the scope of another. If the General Assembly does not provide clear definitions, the responsibility could arrive back at the door of the North Carolina Medical Board, which has been given the authority to regulate the practice of medicine and surgery. So far, the Board has taken what it considers to be thoughtful and responsible actions in various areas affecting

physicians, surgeons, physician assistants, nurse practitioners, nurse midwives, EMS personnel, resident physicians, and other health professions, such as clinical pharmacist practitioners, optometrists, and pharmacists.

The Right Place

Take your pick...a court of law, the legislature, the professional organization, or the regulatory board? At one time or another, each of these has driven decision-making on particular issues. For example, in 1997, under Senate Bill 945, the General Assembly directed that "drugs identified as having narrow therapeutic indices shall be designated by the North Carolina Secretary of Human Resources upon the advice of the State Health Director, North Carolina Board of Pharmacy, and the North Carolina Medical Board." As a result, each year the process of identifying those drugs that fit into this category falls to those entities given authority by statute. The Board is aware that the legislature may choose to write statutes that direct one or more regulatory boards to work out the regulatory details of a particular issue.

The North Carolina Medical Board urged passage of House Bill 1049 in the 1999 and 2000 sessions of the General Assembly to attempt to improve the ability of the Board to properly regulate and discipline physicians and to make the unlicensed practice of medicine a felony instead of a misdemeanor. However, the General Assembly balked on the latter point when a cadre of naturopathic and homeopathic practitioners and their supporters voiced vehement opposition to it. Legislators heard the unlicensed practitioners talk publicly about their practices, knowing that those practitioners have no statutory basis for practice in this state at this time. Not a single legislator publicly remarked about the lack of statutory authority in North Carolina to practice naturopathy or homeopathy. Grassroots activism, including e-mail, letters, and telephone calls, forced modification of the bill on that issue. And finally, the entire bill died for lack of action by the Senate.

Six years ago, when optometrists strove to include 150 additional CPT codes in their scope of practice, the ophthalmologists and other physicians and surgeons, and even the Medical Board, became active at the judicial level to block such action. To resolve such attempts to expand the scope of optometry, a Consent Agreement was signed under which such changes must be approved by all the disputing parties that signed the agreement, including the Medical Board. Since then, further requests for modification of

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Choosing the Right Words

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optometry's scope of practice have surfaced periodically. However, due to the Consent Agreement, unless every party to the agreement approves, NO CHANGE CAN TAKE PLACE! One has to wonder whether such an agreement is the right vehicle for the determination of the scope of practice, or whether it is time for the General Assembly to clarify its intent concerning the scope of practice of optometry.

Political powers should tread gently in determining the scope of practice of health care professions, especially when ethical considerations in government cry out for fair play and equal rights for everyone's profession. Regulatory boards derive all their authority from legislatures. Hence, regulatory boards should stay within their areas of responsibility.

The convergence of events sometimes enlightens us to the irony of these endeavors. Within the same month the North Carolina Medical Board heard ophthalmologists state that there was no possible way that an injection in any form by an optometrist could be considered within the scope of practice of optometry, we heard pharmacists asking for the ability to expand their scope of practice to give multiple types of injections at pharmacies, outside the purview of the patient's personal physician. Thousands of insulin-regulated diabetics inject themselves every day in North Carolina and no one has considered this to be "practicing surgery." Nurses provide injections regularly with skill and predictably excellent outcomes for millions of our citizens and it is not considered "practicing surgery." This all brings me to the last point.

The Right Time

Medical knowledge marches on. Modern medical technology will always push us to be faster, more precise, more efficient, with higher quality and improved outcomes. That is the nature of progress. Every medical professional struggles to keep up with the ever-expanding database and skill requirements in medicine. Do our continuing education attempts really ensure our competence? Do the acquired skills you have learned since your graduation from professional school mean anything? Of course they do! Your database is better, and your skills are at a higher level. Are the skills you have acquired since your licensure as a health professional of any real value? Of course they are! Does all this medical training after licensure or after graduation affect your scope of practice? It all depends on whom you ask! Some say, "Training does

not necessarily change your scope of practice."

The easy answer is to agree that if you really do know what you're doing in your specific piece of the medical specialty you practice, then you will likely be able to pull it off. You provide top-notch health care services, probably within your scope of practice and standard of care. You feel comfortable. The patient gets good service. Everyone is happy...unless you have trodden into another profession's scope of practice. You may then need to look to your attorney for guidance, or call your legislator and get everyone else to do the same. Remember that democracy is the will of the people, but there are definitely principles involved. Grassroots activism cannot totally obviate principle.

The Medical Board works to balance the issues on the principles involved in our progressive medical environment. The Board believes that it has the authority to regulate the practice of medicine and surgery and to refer for legal action any situation that might be considered the unlicensed practice of medicine. Sometimes we take action, and sleep soundly. Other times, we second-guess ourselves, review issues again, and strive for the solution. Jim Elliott, a missionary to the Auka Indians in Peru, once said, "Indecision is the true enemy of successful performance." At times, we push to make a decision and must reconsider certain actions in light of additional information. The struggle is to use the right words, in the right place, and at the right time. ♦

Dialogue on Public Health

Public health issues are a concern, not only for the medical community, but also for individuals and families across North Carolina. Now there's a forum to discuss many of those issues and to provide accurate, up-to-date information to the public as well. A 12-month series of call-in programs on the Open Public Events Network (OPEN) begins with a discussion about asthma on November 16 at 9:00 PM. The call-in series, which is sponsored by the Division of Public Health, Department of Health and Human Services, will continue on the second Thursday of every month at 9:00 PM on various public health topics.

OPEN programs give citizens an opportunity to call in and talk with public officials about a broad range of topics of statewide interest every Tuesday and Thursday from 8:00-10:00 PM. For a list of cable systems carrying OPEN programs, including the series on public health, or to receive monthly program schedules, call 919-733-6341, e-mail open@ncmail.net, or go to www.doh.state.nc.us/doh/apt/cablest.htm. ♦

Feedback

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Legislative Lessons Learned

An example of self-corrective action is found in the Board's recent attempt to bring improvement to its statutory foundation, the Medical Practice Act (MPA). Under North Carolina law, the Board cannot use any funds to promote or oppose legislation. It must, therefore, rely on legislative leadership to shepherd corrective actions. Unfortunately, while the Board's legislative initiative (House Bill 1049) passed the House in this last session, it died in the Senate due to strong opposition to the bill in that chamber. The Board will be evaluating the feedback from this process to determine how best to achieve in the next legislative session the improved approaches to public protection it seeks. The following is some feedback generated in the course of this recent legislative experience.

- The Board sought to make the penalty for the unlicensed practice of medicine a felony instead of a misdemeanor. There was substantial opposition to this provision from supporters and practitioners of so-called alternative medicine. Some of these were duly licensed physicians. The legislation was perceived as a threat to alternative medicine. In actuality, the legislation did not change in any way what constitutes legal or illegal behavior by unlicensed persons. It

"It seems prudent to separate the issues affecting unlicensed people from the issues of improving the process for licensed physicians"

only changed the penalty for engaging in such illegal behavior. The legislation, however, was painted as an attack on practices such as naturopathy and homeopathy. There are no naturopathic or homeopathic licensing statutes in North Carolina, and, thus, there are no licensing boards for naturopathy and homeopathy. Yet, several persons identifying themselves as naturopaths testified about the validity of their practices and the threat presented by increasing the penalty for their unlicensed activities.

In the House, there was an amendment to HB 1049 to set up a legislative research commission to look at all the issues concerning these various unlicensed practitioners, but the amendment, along with HB 1049, died in the Senate. The feedback we received in connection with this legislative

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effort seemed to paint the Board as a group of physicians trying to protect its turf and exclude so-called alternative medical practitioners from the market place. From the Board's perspective, this is certainly not the case. The Board recognizes the significant marketplace in alternative medicine (by some estimates, a 4 billion dollar a year enterprise) and the importance of physicians having a working knowledge of alternative medical practices (many of their patients may be taking alternative substances that can interact with prescribed medicines). The Board was simply concerned that there are individuals engaging in activities that are defined in the MPA as the practice of medicine who have had no screening and validation for training credentials, have passed no licensing examination, and have no licens-

ing board as a recourse for consumers who are dissatisfied or in some way harmed. In short, they are in violation of the MPA. These individuals are unaffected by the penalty for unlicensed practice as it now exists and the Board proposed a remedy. As I've noted, there was a significant backlash in the legislature to this proposed remedy.

The Board is reassessing what consumers in this state expect from its licensing system and whether the Board or some other entity should be the catalyst for corrective action in light of substantial consumer response. Unfortunately, this consumer response had the effect of chilling the Board's recommended improvements in other important areas with respect to public protection mechanisms involving physician licensees. The Board will deliberate over the lessons learned. At the very least, it seems prudent to separate the issues affecting unlicensed people from the issues of improving the process for licensed physicians.

Pain Management and Drug-Seekers

The Board members and staff spend a lot of time giving speeches to various organizations such as hospitals, medical societies, and consumer groups. This provides a valuable feedback mechanism. The following is an example of feedback from some recent activities.

- *The Position Statements of the North Carolina Medical Board* includes a statement on the management of chronic non-malignant pain. The beginning of that statement reads: "It is becoming increas-

ingly apparent to physicians and their patients that the use of effective pain management has not kept pace with other advances in medical practice." It goes on to define pain categories and appropriate mechanisms for treating chronic pain, including a list of 11 suggested elements for effective management. It ends with the comment that no physician need fear reprisals from the Board for appropriately prescribing, as outlined in the statement, even large amounts of controlled substances indefinitely for chronic non-malignant pain. This position statement is consistent with national recommendations and guidelines intended to sensitize physicians to suggestions that chronic non-malignant pain may be inadequately medicated by some physicians who fear medical board intervention.

When presented to practitioners in the field, including hospital physicians and pharmacists, this statement is well received, but there is feedback about a real-life situation that also plagues these practitioners: professional drug-seeking patients. The existence of these so-called patients in all state medical board jurisdictions is well documented. They are particularly well documented in states where there are triplicate prescription programs documenting their activity, such as seeking controlled substances from several physicians and pharmacies simultaneously.

An example of a patient encounter that presented a dilemma for a practicing physician was raised at a recent meeting. A physician described a patient he suspected was abusing controlled substances, he referred the patient to a pain clinic, and the patient responded to the physician that if the physician did not continue to maintain his prescribing for the patient, the patient would burn the physician's house down. This is an extreme example of a drug-seeking patient who is engaging in criminal behavior and, in the process, is pressuring prescribing physicians and dispensing pharmacists to aid in the criminal behavior. This is a concept that is often referred to by federal authorities as concurrent liability: prescribing physicians and pharmacists can be considered engaging in illegal activity for participating in obvious criminal behavior, the diversion of controlled substances. The message from this session was that, while

we have focused a lot of necessary attention on the importance of managing chronic non-malignant pain, we must also consider helping those practitioners who daily face the dilemma presented by drug-seeking patients – avoiding any involvement in illegal diversionary schemes.

Views on Discipline

Yet another message comes from our critics, who at times seem abundant. Medical boards are either doing too much or too little in terms of disciplinary orders. Of course, there is far more criticism in the latter category.

- This Board receives over 600 complaints from patients each year. Most of these are triggered by poor communication, which may or may not be coupled with poor outcome or unprofessional behavior. Most everyone who complains expects a disciplinary action in response. Then there is the licensee. He or she reads the last four or five pages of the *Forum* and regularly sees what peers are sanctioned for. At times, it appears all you have to do is have a bad day at the office and you are branded for the rest of your career. This

"No one gets a public disciplinary action without opportunity for a hearing unless there is imminent risk to the public health, safety, and welfare that requires emergency action"

fear is exacerbated when reading the summary narrative behind the reported actions. Licensee feedback suggests that what sometimes appear to be relatively minor incidents result in public discipline. From the Board's perspective, minor incidents don't result in public disciplinary action. There is full due process afforded by law before any public disciplinary action is taken, and the events leading to such action have to

be supported by a preponderance of the evidence. No one gets a public disciplinary action without opportunity for a hearing unless there is imminent risk to the public health, safety, and welfare that requires emergency action. In those few cases requiring emergency action, a licensee has an opportunity for an expedited hearing. The due process mechanisms available to a licensee are perhaps not apparent to those licensees who read the list of actions in this publication, and a licensee may be left with the impression he or she could end up on these pages simply for being the target of a vitriolic patient.

These divergent reactions from consumer groups and complainants on one side and licensees on the other are constant for most medical boards. A simplistic view (mine) is that medical boards function on a continu-

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um. At one end, the board clearly doesn't do its job. Licensees who are outliers are 100% happy – no one gets disciplined. (Notice that I qualified the licensee response. I think the majority of good and diligent physicians would be unhappy because the outliers would represent a significant blight on their profession. This would have a negative impact on them and the medical community. For the sake of simplicity in outlining the continuum concept, we will leave this majority of licensees out.) At the same time, consumers are unhappy. No one is protecting them from outliers in the licensee population. At the other end of this continuum, the board is draconian – it imposes discipline as a result of almost all complaints; thus most of the complainants are happy. Licensees are unhappy – they do not have due process protection. Every time a complaint comes in, a physician is sued, or there is a bad medical outcome, someone is disciplined. The board is fully responsive to its consumer critics. Consumers don't complain about the board, but licensees do. The board works on the assumption that a complaint must have merit or a bad outcome must be punished. On this end of the continuum, there is a true sense of urgency. The magnitude of the consequences of medical error are staggering. A summary of the Institute of Medicine report entitled *To Err Is Human: Building a Safer Health System* (which may be found at <http://books.nap.edu/catalog/9728.html>) finds that "... as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS – three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems."

Some consumer watchdog agencies tell us that medical boards should be taking many more disciplinary actions – in effect, we need a substantial phase shift on the continuum. This may be true, but there are some with unrealistic expectations. An extreme view, one taken at the polar end of the continuum, is that malpractice equates with incompetence and medical error should necessarily be met with a punitive response. (By the way, a medical board could only function on this end of the continuum in another country, because there would be no due process for the licensee.)

Where should a medical board be on this continuum? Perhaps it belongs somewhere in between, tilting in favor of the consumers that medical licensing laws were designed to protect while providing full due process afforded by law to licensees. That means some bad outcomes and consumer complaints will go unpunished. Meanwhile, critics on either end of the continuum will not be happy. Most medical boards get negative feedback from those who advocate more extreme ends of the continuum. This feedback is important to our Board, even though it is almost always negative. Feedback tells us we need to work both sides of the argument. We must be responsive to concerns of consumers about public protection and to concerns of licensees and their lawyers that we act within the law and afford full due process protections of the law. An argument can be made that if a medical board is being criticized from both extremes, it is probably moving in the right direction in terms of protecting the public. People on both sides of the issue need to know what this Board is doing to protect their interests, and we make every effort to let them know.

"An argument can be made that if a medical board is being criticized from both extremes, it is probably moving in the right direction"

Conclusion

These are but a few examples of this Board's sensitivity to feedback. The Board members and staff are readily available to meet with any group to explore these and other issues. We routinely meet with medical society groups, hospital staffs, medical students, deans of the medical schools, civic groups, legal groups, and associates in other states for this purpose. The Board's current president, Mr Wayne VonSeggen, has appeared before a dozen or more groups during his presidential year. Its upcoming president, Dr Elizabeth Kanof, is already planning a special group of presentations across the state. This represents part of our continuing effort to solicit your input and feedback. You can give us your comments by e-mail (info@ncmedboard.org), by fax (919.326-1130), by post (PO Box 20007, Raleigh, NC 27619), or by telephone (919.326-1100/800.253-9653), as you deem appropriate. If you would like a representative of the Board (Board members and/or staff) to address your group or organization, please let us know and we will do our very best to accommodate you. ♦

NCMB Announces Hiring New Medical Coordinator: Gary M. Townsend, MD, JD

Andrew W. Watry, executive director of the North Carolina Medical Board, has announced that Gary M. Townsend, MD, JD, a native of Virginia, has been selected to replace Jesse Earle Roberts, Jr, MD, as the Board's medical coordinator. Dr Roberts left the medical coordinator's position in March 2000 after almost three years of service.

Following his graduation from Duke University in 1972, Dr Townsend received his MD degree from West Virginia University in 1976. He obtained his JD from George Washington University in 1980. He has been licensed to practice medicine in North Carolina since 1979 and is also licensed in Maryland, Pennsylvania, Virginia, and West Virginia. He is a member of the bar in Pennsylvania and West Virginia.

Dr Townsend has practiced emergency medicine since 1978 in Pennsylvania and Maryland, and most recently at Dorchester General Hospital in Cambridge, Maryland. He has also practiced as a medical-legal consultant, first on active duty with the U.S. Air Force from 1986 to 1992, and, from then until the present, as a civilian with the Consultation Case Review Branch of the Office of the Surgeon General, U.S. Army Quality Management Directorate, located at Walter Reed Army Medical Center in Washington, DC.

A flight surgeon with the 167th Airlift Wing of the West Virginia Air National Guard since 1994 and commander of the 167th Medical Squadron since 1997, Dr Townsend holds the rank of colonel.

His duties with the Consultation Case Review Branch were quite similar to the tasks he will undertake for the Board. The medical consultant's role is to assist and advise the Board and the staff in areas requiring general medical expertise and in the screening and evaluation of complaints involving medical care issues.

"We are delighted to welcome Dr Townsend to the Board's staff," Mr Watry said, "and are pleased with the experience and expertise he brings to the position of medical coordinator. Over the past three years, our case review systems have improved remarkably thanks to the efforts of our outstanding Complaints Department staff and to the hard work and dedication of our first medical coordinator, Dr Roberts. Dr Townsend is well equipped to continue in that tradition and add to it in meaningful ways. We look forward to working with him." ♦

Domestic Violence: Part 2

Battered Men: Another Story

Laura A. Queen

Outreach Coordinator, Women's Aid In Crisis, Upshur County, WV

Billboards and radio and television ads across the country proclaim that every few seconds a woman is beaten by a man. Violence against women is clearly a problem of national importance. The United States Department of Justice estimates that 95% of reported assaults on spouses or ex-spouses are committed by men against women. In the three years I have been a domestic violence victim advocate in this county, I have provided services to 450 clients, 10 of whom were males.

Why the Silence?

While the very idea of men being abused by their partners runs contrary to many of our deeply ingrained beliefs about men and women, female violence against men is a phenomenon almost completely ignored by the media and society.

Violence takes on many forms. There is no question that since men are, on average, bigger and stronger than women, they can do more damage in a physical assault. However, not all men are bigger than their female partners and not all abuse is physical, a fact that is pointed out over and over when describing domestic violence.

And what of female-on-male violence? Why don't we hear about it more often? For several reasons. First, men in general are extremely reluctant to report that they have been the victims of any assault. After all, men are supposed to be tough, able to take care of themselves, right? What would people think. . . ? Men are trained to solve their own problems, not to ask for help. Second, confessing to being knocked around by another man is a piece of cake compared to admitting being abused by a woman. Why? Most likely, men fear, rightly so, society's traditional reaction. In France in the eighteenth and nineteenth centuries, a husband who had been pushed around by his wife would be forced by the community to wear women's clothing and to ride through the village sitting backwards on a donkey, holding its tail.

"Female violence against men is a phenomenon almost completely ignored by the media and society"

ety's reluctance to acknowledge the female potential for violence. First, women are subtly encouraged to be more violent, eg, mothers tell their daughters: "If he gets fresh, slap him." Second, while it is possible to argue that a slap is unlikely to do any severe damage, not recognizing that a slap is still violence sets a dangerous precedent. Arresting a man who slaps a woman, while dismissing a woman's slapping of a man as nothing to worry about, both condones violence and reinforces a double standard that historically has been used to oppress women in the name of protection.

Men's victimization cannot be denied, however a few questions still remain. First, if men are so much bigger and stronger, why don't they protect themselves? The answer makes perfect sense. At the same time little girls are being told it is okay to slap, little boys are being told, "Never hit a girl." And when these little boys grow up, they

are told that any man who hits a woman is a bully. But if a woman hits him, he is supposed to "take it like a man." Also, many men recognize the severe damage they are capable of doing and, therefore, consciously try to limit it. One male client I worked with stated that his partner used the knowledge that he would not strike back and continued the abuse. Another, after years of physical abuse at the hands of his wife, struck her in the face after she assaulted him. She called the police, who, upon arrival, arrested him for domestic battery, not believing his story that she struck first.

Leaving the Relationship

Not fighting back is one thing, but why would any sane person stay in an abusive relationship? I have learned in advocating for men as victims that their reasons differ little from women's.

Economics plays a part. As more women enter the work force, it is getting harder and harder to find a traditional "man-as-the-sole-breadwinner" family. Men are becoming more dependent on their partners' incomes for family survival.

Many women fear that if they leave their husbands, the violence they have experienced may be directed against their children.

Abused men, too, are just as concerned for their children and want the family unit to remain in tact. Moreover, since women still

"Continuing to portray partner violence solely as a women's issue is wrong, it is counterproductive"

get physical custody of children in over 85% of all divorce cases, many men are hesitant to leave, realizing that if they do the courts may severely limit their access to their children.

For men, deciding to leave an abusive relationship is only half the battle. The other half is: where do they go, who will believe them? It seems that, in reality, barriers to a male victim of domestic abuse are very much the same as those facing a female victim just a few short years ago.

Conclusion

Resources and facilities to combat domestic violence are out there, but, unfortunately, are still in short supply. Perhaps some battered women's groups fear that if society recognizes that men are victims too, what little money that is available will be diverted.

Continuing to portray partner violence solely as a women's issue is wrong, it is counterproductive. No one has a monopoly on pain and suffering. Until society recognizes all the victims of domestic violence, we will never be able to solve the problem.

Domestic violence is neither a male nor a female issue – it is a human issue.

About the Author

Ms Queen is the author of the article on domestic violence that appeared in the previous number of the *Forum*. She is a talented West Virginia artisan who, along with her husband, handcrafts unique and beautiful kitchen utensils from native woods: maple, cherry, walnut, and hickory. Much of her time is spent in the frontline fight against spouse and child abuse. She has helped rescue hundreds of women and children from all types of abuse, assisting them in putting their lives back together. As this article makes clear, she is also no stranger to the abuse of men by their female partners. Her voice has the ring of truth tempered by experience and she can tell stories that will bring tears to anyone's eyes. ♦

The Female Potential for Violence

There are several serious effects of soci-

Using the NCMB's DataLink Software

*Donna Masho, CMSC
Alamance Regional Medical Center*

*Kay Gibson, CMSC
High Point Regional Health System*

About five years ago, a group of members from our professional organization, the North Carolina Association of Medical Staff Services (NCAMSS), met with Bryant D. Paris, Jr, then executive director of the North Carolina Medical Board (NCMB), and H. Diane Meelheim, assistant executive director of the NCMB, to discuss what information would be helpful to the medical staff professional if it were available on software. A second meeting was held on April 3, 1998. Three of us from the NCAMSS, Kay Gibson, Deborah Chapman, and Donna Masho, attended the meeting. Attending from the NCMB were its then new executive director, Andrew W. Watry, Ms Meelheim, and Rebecca Manning. The purpose of the second meeting was to discuss the software of the NCMB's DataLink system, problems encountered in medical staff offices, and the benefits derived from having access to practitioner licensing information on a continuing basis.

Problems and Solutions

The main point of our discussion at the April 3 meeting was the new state guideline for license renewal dates (annually, on the practitioner's birthday). It has had an impact on the medical staff office because of a 60-day period that the license may be in limbo due to the wording of the statute. It was the consensus of the group that there was not much we could do about the way the statute is worded, but that we could work toward establishing a process that would be acceptable to the NCMB, hospitals, and licensing and accrediting agencies. A medical staff professional's worst nightmare would be finding an unlicensed physician on the staff of his or her hospital.

Those of us from NCAMSS found Diane, Rebecca, and Andrew to be very aware and concerned about our problems, with a real willingness to help correct them. Several ideas were discussed. We all agreed that the more we can do through the software program, the better it would be for everyone. For example, added to the program was to be a tickler file informing us of the date on which the Board sent the letter of renewal to the physician, who has 30 days to respond.

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NCMB Adopts Position Statement on Office-Based Surgery

At its meeting in September, the North Carolina Medical Board adopted the following Position Statement on Office-Based Surgery.

Office-Based Surgery

Office-based surgery is surgery* performed outside a hospital or an outpatient facility accredited by the North Carolina Division of Facility Services. Although surgery is not a perfect science in any setting, office-based surgery is generally safe, effective, and efficient, provided proper measures are taken in the process. It is the position of the North Carolina Medical Board that the physician is responsible for providing a safe environment for office-based surgery.

The following general guidelines are recommended for office-based surgery.

• Training:

Any procedures, whether done in an office or a hospital, should be performed by physicians operating within their area of professional training. Appropriate training and continuing medical education should be documented and that documentation should be readily available to patients and the North Carolina Medical Board. Those who perform office-based surgery must have plans, such as pre-arranged hospital admission protocols, for managing emergency complications.

• Patient Selection:

Patients must be evaluated per procedure to determine if the office is an appropriate setting for the surgery.

• Patient Evaluation:

Patients undergoing office surgery must have an appropriately documented history and physical examination, and any other studies or consultations indicated.

• Anesthesia:

When general anesthesia or sedation is provided in the office setting, it must be administered by those qualified to do so. Anesthesia personnel should be familiar with variations in technique based on the specifics of the patient and the procedure, particularly those requiring large volumes of fluids or airway management. Patients must be properly monitored before, during, and after the procedure. Physicians are referred to the protocols of the

American Society of Anesthesiologists** for guidance. ACLS certification of anesthesia personnel is an important consideration.

• Office Setting:

The office should be set up with patient safety as a primary consideration. Safety issues should include, but not be limited to, accessibility, sterilization and cleaning routines, storage of materials and supplies, supply inventory, and emergency equipment.

• Emergency Planning:

Planning should include, but not be limited to, emergency medicines, emergency equipment, and transfer protocols. Practitioners should be trained and capable of managing complications related to the procedures they perform.

• Follow-Up Care:

As with any surgical treatment or procedure, follow-up care by the responsible surgeon is requisite. Arrangements should be made for follow-up care and for treatment of problems or complications outside normal office hours.

• Quality Improvement:

Continuous quality improvement should be a goal.

* Definition of surgery as adopted by the NCMB, November 1998:

"Surgery, which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skills, post-operative management, and follow up."

** "Guidelines for Office-Based Anesthesia," "Guidelines for Ambulatory Anesthesia and Surgery," "Basic Standards for Preanesthesia Care," "Standards in Basic Anesthetic Monitoring," "Standards for Post-anesthesia Care," "Guidelines for Nonoperating Room Anesthetizing Locations." All available from the American Society of Anesthesiologists.

[Adopted September 2000] ♦

Prescriptions: Legal and Legible

Donald R. Pittman, Field Supervisor
NCMB Investigative Department

A pad of prescription blanks is found in every physician's office from Murphy to Manteo, and as long as one is readily available to the physician, who gives it a second thought? Please read on, you may learn that many have and are giving the physician's prescription blank a second thought! Pharmacists, nurses, patients, and regulatory board investigators have all raised questions about the pre-printed information and the handwriting on the physician's prescription blank.

Pre-Printed Information

According to CFR (Code of Federal Regulations) 1306.05, all prescriptions for controlled substances shall be *dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name, address, and registration (DEA) number of the practitioner*. The prescription may be prepared by the secretary or agent for the signature of a practitioner, but the prescribing practitioner is responsible in case the prescription does not conform in all essential respects to the law and regulations. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by these regulations.

NC General Statute 106-134.1(a) (4) a, reads, ". . . written prescription must bear the **printed or stamped name, address, telephone number, and DEA number** of the practitioner in addition to **his legal signature**." This NC statute requires the referenced information be on a prescription blank whether the prescribed drug is a controlled substance or non-controlled substance (legend drug). However, if you are a physician, physician's assistant, or nurse practitioner who does not have a DEA registration number, then you are not permitted to prescribe controlled substance medications, only legend drugs, and, obviously, you are not required to put a DEA number on your prescription blanks.

In addition to the federal and state regulations noted above, nurse practitioners are required by North Carolina Medical Board rules to record the prescribing number assigned to them by the medical board and the name of their supervising physician(s)

on each prescription blank. Physician assistants are required by similar Medical Board rules to record their license number and the responsible supervising physician's (primary or back-up) name and telephone number.

Having cited these CFR and NC General Statute/Rule references, you may ask what all this means. First, every prescription blank must contain simple, basic information: name, address, telephone number, and DEA number of the prescribing physician or physician extender. It is this basic information, either missing or in error, that is causing many to have second thoughts and questions about physicians' prescription blanks.

Handwriting

When you couple that lack of required information on a prescription blank with the serious and not uncommon problem of scrawled and even indecipherable physician handwriting, you have created extra work for the dispensing pharmacist, who may have to delay delivery of medication(s) to a patient. The pharmacist cannot dispense medication to a patient until he or she has confirmed who the prescribing physician is and/or what medication/dosage was intended to be dispensed. Whatever the source of the pharmacist's dilemma, it is one fraught with the potential for error.

Pharmacists have called the Board's office to report they were unable to fill a specific prescription because they could not read the physician's signature and the prescription blank did not have the physician's name pre-printed on it.

Two examples of prescription blanks not having physicians' names pre-printed on them are those found in hospital emergency rooms or county health departments. When the pharmacist receives such a prescription and the physician's signature is no more than a squiggly line, he or she must make an attempt to call the clinic/hospital to find out who wrote the prescription. Depending on the day and time of the pharmacist's call, it may prove impossible to speak with the physician who wrote the prescription. In fact, the pharmacist's call may not be answered at all, particularly

if the patient brings the prescription to the pharmacy after the clinic has closed for the day. If unable to confirm who authorized the prescription, the pharmacist may be left with only one option: tell the patient to return the next day after the pharmacist has had an opportunity to speak with the physician. Such delay is an inconvenience to patients and may be harmful to them.

A more serious problem exists if the pharmacist is left to decipher the drug name, strength, quantity, and direction for use when these are handwritten by the physician in an indecipherable scrawl. The Institute of Medicine reported last year that a range of medical errors, including written miscommunication between physicians and other health care professionals, may claim as many as 98,000 lives a year. It has been suggested that doctors' handwriting can be a contributing factor.

Lawsuits have been filed and successfully litigated regarding injury and death due to illegible handwriting. In late 1999, a Texas jury heard a case concerning the accidental death of a 42 year-old man who suffered a heart attack after receiving the wrong medication. The physician intended the patient to be given Isordil, 80mgs per day for heart pain; instead, the pharmacist misread the doctor's handwriting and dispensed Plendil, 80mgs per day, a drug to treat high blood pressure. Maximum recommended daily dose of that drug is 10mgs. The victim's family was awarded several hundred thousand dollars.

Conclusion

So, if you want to avoid getting telephone calls at all hours of the day and night from pharmacists stumped by your handwritten prescriptions, and, even more bothersome, if you want to avoid that hard bench at the courthouse courtesy of litigation, include all the required pre-printed information on your prescription blanks and be sure others can read and decipher your handwriting. When pharmacists do call to inquire about patients' prescriptions, please answer their questions in a professional manner. Maintaining open communication and rapport is the best medicine for the patient. ♦

"Lawsuits have been filed and successfully litigated regarding injury and death due to illegible handwriting"

"Pharmacists have called the Board's office to report they were unable to fill a specific prescription because they could not read the physician's signature"

From the North Carolina Board of Pharmacy

Focus on Prescriptions

David R. Work, Executive Director, North Carolina Board of Pharmacy



Mr Work

Prescriptions and New Technologies

Various new methods of transmitting prescriptions have generated questions from physicians and other prescribers. Systems now exist for generating prescriptions through a word processor or computer and this is just one example of new technology begetting more questions. Pharmacy Board rules provide for electronic (.1814) and fax (.1807) transmission of prescriptions, with several specific requirements.

Perhaps the most significant technology limitation on prescribing pertains to controlled substances. Federal regulations generally prohibit the fax transmission of prescriptions for Schedule II drugs such as morphine or Dilaudid®, except for specific situations such as hospice patients or patients in long-term care facilities.

At the state level, the responsible state agency with jurisdiction over controlled substances is the Controlled Substances Drug Regulatory Branch of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. It is their position that prescriptions for controlled substances can be individually generated by a computer and would be legal provided the prescriber manually signs the document.

It is worth noting that only 10 to 15 percent of prescriptions are for controlled substances, so the great bulk of prescriber's orders are easily transmitted either by fax or electronically in the same way as e-mail. By way of comment, the Pharmacy Board staff recommends fax transmission rather than telephone orders on both new prescriptions and refill authorizations for several good reasons. One is that there is a written record of what was prescribed or authorized, which promotes accountability. Another reason is that pronunciation issues (Xanax® vs Zantac®) are avoided and the time/date/source tagline can verify validity.

Although bogus prescriptions can occur in any system, we have seen many more forgeries with phony telephone orders or stolen prescription pads. This is a good reminder for prescribers to keep closer track of their unused prescription documents.

The status of a particular drug can be determined in two ways. First, and easiest, is to make a list of the drugs commonly used in your practice and ask your local pharmacist which can be ordered electronically or by telephone or fax and which must be ordered in writing. Or each drug can be found in a standard reference such as *Facts and Comparisons* or *The American Drug Index*, both available from their publisher at 800.223-0554. The *Physician's Desk Reference* is useless for this task because it is an incomplete reference of some, but not all, brand name drugs, and generics are not included.

Drug Substitution

Physicians who are concerned about drug substitution need to be aware of the functioning of the state's Product Selection (substitution) Law. The current statute allows the substitution of a generically equivalent drug for brand name drugs unless the prescriber overrides the pharmacist in one of several ways. The first method is by using a two line prescription form that is prescribed by statute (one line with "Dispense As Written" on the lower right-hand side of the prescription and one line with "Product Selection Permitted" on the lower left-hand side). Another is to write the words "Dispense As Written" or "DAW" on the face of the prescription. If the prescription document is in another format, such as a one line form, or if the prescriber fails to write "DAW" on the face of the prescription, then the pharmacist is able to use the generic version of the drug.

NTI Drugs

The Product Selection Law also incorporates the Narrow Therapeutic Index (NTI) concept into state law. This specific part of the statute states that drugs that require blood monitoring, or have formulation-dependent variability, or whose toxic dose is less than twice the effective dose must be refilled with the same manufacturer's product used on the prior filling. If the pharmacist, or health plan, wants to change to a different manufacturer, then the pharmacist

must get the documented consent of both the prescriber and the patient prior to switching products. Drugs currently on the NTI list are listed below.

- carbamazepine (all dosage forms) [Tegretol®, various others]
- cyclosporine (all oral dosage forms)
- digoxin (all dosage forms) [Lanoxin®]
- ethosuximide (all oral dosage forms)
- levothyroxine sodium tablets [Levothroid®, Levoxyl®, Synthroid®, various others]
- lithium (all oral dosage forms, all salts) [Cibalith®]
- phenytoin (all oral dosage forms, all salts) [Dilantin®]
- procainamide hydrochloride (all oral dosage forms)
- theophylline (all oral dosage forms, all salts) [Elixophyllin®, Slo-Phyllin®, Slo-Bid Gyrocaps®, Theochron®, Theo-Dur®, Theo-24®, Uniphyll®]
- warfarin sodium tablets [BMS Warfarin®, Coumadin®, Warfarin®]

Printed Forms

For many years, state statute has required that all written prescriptions must bear the printed name, address, telephone number, and DEA number of the prescriber. This exists primarily for a public health reason, which is to provide pharmacists with a name and telephone number to contact in case questions about the prescription arise. The most significant instance when this does happen is when someone goes to a teaching medical center for diagnosis and then brings prescriptions back to his or her home community. It is not unusual for the documents to be clearly written until the prescriber's name appears at the bottom with a scribble or a swoosh that doesn't give the pharmacist any reliable reference in case questions exist about dosage or potential drug interactions. The presence of a printed name and telephone number makes it possible for the pharmacist to resolve any questions that might arise.

Conclusion

If you have any questions about these or other pharmaceutical matters that might involve the Board of Pharmacy, we suggest you review the Board's Web page at www.ncbop.org, scrolling to Frequently Asked

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Focus on Prescriptions

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Questions or New Developments. There is also a section on Drug Law that some may find interesting. Another good source of information is the USP and their Web site at www.usp.org. They have a program involving medication error reporting and prevention that has several specific recommendations, including the electronic transmission of prescriptions in lieu of handwritten documents. On their Web site, click on Practitioner Reporting, the National Coordinating Council on Medication Error Reporting and Prevention (NCCMERP), and then Council Recommendations. ♦

Treating Bias

Researchers have no evidence that American physicians withhold medical care from minority and poor patients out of some type of bias. But there is no end of evidence that minorities and the poor routinely receive inferior care, with the obvious result of shortened lives or chronic illnesses that mar their quality of life. That is intolerable.

The latest report pointing to racial and socioeconomic disparities in medical treatment comes from close by. Dr. Kevin Schulman, a Duke University internist, co-authored a study that found a pattern in which hospitals sometimes fail to recommend simple, inexpensive therapies such as aspirin to poor or African-American heart attack victims upon their discharge from hospitals. The study, which involved nearly 170,000 Medicare patients, was recently published in a medical journal.

The gap in quality of care wasn't as wide as a chasm. But it was marked, and in real numbers affects thousands of people. Other studies also have shown that the poor, Hispanics and blacks of all income levels tend to be treated differently than their white or more affluent counterparts for the same illnesses.

Schulman thinks the way hospitals work, especially ones with high loads of poor patients, is to blame. If that is so, hospitals could fix some shortcomings by, for example, handing out written instructions to patients who suffer from the same malady. Still, Congress (or the states) needs to pass legislation, already introduced in the U.S. House and Senate, that would require medical students to be trained about cultural differences. Bias, whether knowing or inadvertent, has no place within the healing art.

Editorial reprinted with permission from *The News & Observer* of Raleigh, North Carolina, 8/15/2000. ♦

A Brief Guide to Continuing Medical Education Requirements for Physicians in North Carolina

A continuing medical education (CME) rule for physician licensees of the North Carolina Medical Board became official in July 2000. Adoption of the rule was the result of a legislative mandate that can be found in *NC General Statutes* 90-14 (a)(15). The rule itself appears at the end of this Guide and may be found in the *NC Administrative Code* at Title 21, Chapter 32, North Carolina Medical Board, Subchapter 32R-Continuing Medical Education (CME) Requirements.

When Does the Rule Become Effective?

It becomes effective in 2001. You will need to obtain and document for your files the required practice-relevant CME starting with your birthday on or after January 1, 2001. **You will be asked to report your total hours of applicable relevant CME each year on your annual license registration form, but you will have three (3) years to meet the requirement.** Thus, the first licensees required to have at least the 150 hour total (as defined in the rule) will be those with birthdays in January who register in 2004 and have been licensed for at least three years. Others will have to meet the full requirement by the month in which they register in 2004 (if they have been licensed for at least three years at that time).

Simply put, **for a physician licensed before January 1, 2001, the three-year CME cycle begins on his or her birthday in 2001. For a physician licensed during or after 2001, the CME cycle begins on his or her first birthday following the granting of the license.** (Some examples of individual situations are provided below in the section How Does the Three-Year Cycle Work?)

How Can I Prepare for Reporting and Documenting My CME?

We strongly recommend you **set up a system now** for demonstrating compliance. This will be easier than waiting until the last minute and will help ensure the system is as comfortable as possible for you in your circumstances. As you know, we have been asking for CME reports on annual registration forms for some time, even though there has not been a CME requirement in place for physicians. Therefore, thinking about CME reporting in the context of annual registration should be natural. You will find a CME report segment on the registration form in 2001, as usual, with only some changes in

wording to remind you that CME is now required and that you should maintain documentation of CME for six years. (And if you hold licenses in other states requiring CME, you should compare our requirement with theirs to be sure your documentation will be appropriate for each.)

Documentation for **North Carolina Credit 1 CME (provider-initiated)** can be as simple as keeping a dated record of your attendance at or participation in relevant CME programs conducted by ACCME or AOA accredited institutions, along with a file of receipts or certificates verifying the information recorded. **For North Carolina Credit 2 CME (physician-initiated)**, it can be as simple as keeping a list of relevant CME activities initiated by yourself and noting the nature of the activity, the date, and the hours earned.

How Does the Three-Year Cycle Work?

The Board's new CME requirement is based on a three-year cycle, a time period similar to that used by a number of states and medical organizations with CME requirements or programs. However, because the North Carolina system is keyed to your birthday and because of the need to report during your birth month as part of our annual registration process, our system will differ from some others. It may be useful to give examples to demonstrate some of the permutations. Below are some cases we hope will clarify the process for those of you who have questions about how the system will work as reporting begins. Each example assumes the hours mentioned represent relevant CME and that the 150 hour minimum includes at least the 60 hours of NC Credit 1 CME (provider-initiated) required by the rule. **Remember, the three-year CME cycle will vary for each licensee depending on his or her birth month and date of licensing.**

- *Physician A: Licensed in NC during 2000 or before, birthday in January. . .*

The licensee must meet the 150 hour requirement by January registration, 2004. Reports 0 hours in January 2001 (cycle opens, counting begins at this point). Has several options. (1) Can get 150 hours in March 2001, report 150 hours at next registration in January, 2002, report 0 hours in January 2003 and 2004 respectively.

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That will meet the CME requirement as of 2004. Then in 2004, the licensee starts over, working for the 150 hour total that will be needed by 2007. (2) As an option, the licensee can get 150 hours in November 2003, reporting 0 in January 2002 and January 2003, and reporting 150 in January 2004. (3) Finally, the licensee can break it up, reporting combinations such as 50 hours of CME in January 2002, January 2003, and January 2004. In any case, the licensee starts with a clean slate in January 2004, as the cycle starts over.

- **Physician B: Licensed in February 2001, birthday in January. . .**

Does not have to start counting and reporting toward the 150 hours until January registration, 2002. Does not need to have all 150 hours until January 2005.

- **Physician C: Licensed in October 2002, birthday in November. . .**

Receives a registration form in November 2002. Does not have to report any CME on his November 2002 registration form, but has to start counting and documenting CME beginning in November 2002. Has to have 150 hours by November 2005.

- **Physician D: February birthday, gets 150 hours of CME between February 1, 2001, and February 1, 2002. . .**

Meets the requirement early. Reports the 150 hours on February 2002 registration, does not need to report any CME in February 2003 or 2004. However, licensee is diligent about CME and gets and reports 150 hours in 2003 and 2004 respectively. Easily meets the requirement for 150 hours for registration in 2004: only had to get 150 hours but reports 450 hours cumulatively over the three years since his registration in February 2001. Cannot carry hours over to the next cycle, however. Has to start with a clean slate with registration in 2004 and accumulate 150 new hours before February 2007.

- **Physician E: Does not practice in North Carolina but keeps license active, does not set foot in NC during entire cycle. . .**

Location does not matter, has to meet requirement.

- **Physician G: Can only document 50 hours at the end of 3 years, should have met requirement. . .**

Following full due process, including notice and hearing, has exposure to a public disciplinary order. The Board's action may or may not be considered by

another state as a bar to licensure, and it may or may not affect hospital privileges or eligibility for reimbursement by Medicare or Medicaid. Whatever the case, it is not worth it to the licensee.

- **Physician H: Has specialty board certification with a board that has CME requirements that meet or exceed the requirements of the NCMB; specialty board maintains documentation. . .**

The licensee's CME must comply with the NCMB's rule in relation to credit type, quantity, and time period, and the licensee must report his or her CME on the annual registration form. If the licensee is one of those randomly selected for inspection for CME compliance, the documentation provided to the specialty board can be used but it must meet the NCMB's requirements. The fact of certification itself is not documentation.

- **Physician I: Has an inactive license, either because he or she requested it or because of failure to reregister. . .**

Is not registered and, therefore, does not have to comply with the CME requirement unless or until license is reactivated. (Those who hold inactive licenses may not practice medicine in North Carolina.)

How Does the Requirement Apply to Residents in Training

The rule makes clear that licensees who are **residents** enrolled in ACGME or AOA accredited graduate medical education programs are **exempt** from the requirement.

What Is "Relevant" CME?

The idea of relevance is an essential part of North Carolina's CME requirement and sets it apart from such requirements in many other states. **The CME used to satisfy the North Carolina requirement, at either credit level, must relate to your actual practice of medicine.** It seems obvious that CME, to be meaningful, should be focused on maintaining and enhancing your ability to provide care for your patients or for those patients affected by your professional services. When asking yourself if the courses or studies you want to pursue are relevant, answer this simple question: Do they have a direct impact on my care of my patients? If you can make the case that the word and the spirit of the requirement have been met, there should be no problem.

Of course, some physicians do not treat patients or provide professional services related to the treatment of patients. Their tasks are purely administrative or otherwise have no direct effect on patients. CME for them may be management related or institutional in nature. However, if their work

involves review of medical records, significant CME directed to patient care issues would be called for. And if they see or provide professional services for patients on a limited schedule, CME directed to their particular practice should be a significant part of their CME effort. Again, they should be able to make the case that the word and the spirit of the CME requirement have been met.

How Do I Compute My Various CME Activities?

In the case of **NC Credit 1 CME (provider-initiated)**, ACCME and AOA accredited institutions note the credit-hour value of such programs in their printed materials and announcements and on the attendance/participation certificates they give. Simply record these in keeping with the number awarded by the institution.

NC Credit 2 CME (physician-initiated) presents a different situation. Some of the twelve items listed do not fit a neat hour-by-hour scheme, most do. Study, consultations, outcomes research, mentoring, teaching, creation of generic patient care materials, and participation in M&M conferences and journal clubs can be measured by the clock, though activities such as teaching should include the time required for preparation. Competency assessment may involve a variety of activities, all of which should be included in the calculation of time. Passing a specialty board examination can be counted as the maximum three-year NC Credit 2 CME allowance. (Of the 150 hours of CME credit required in three years, at least 60 must be NC Credit 1 CME. All the rest, up to 90, may be NC Credit 2 CME.)

Can I Roll Excess CME Hours Over to the Next Cycle?

No. The CME hours earned within a three-year cycle can be used only to fulfill the requirements for that cycle, which cannot be extended or shortened.

Can I Use the PRA or Similar Awards for Reporting?

Yes and no. You can use the records you kept and reported to the AMA or other organizations to earn their CME awards for documentation, but you must highlight and count only those CME experiences that qualify as relevant, that meet the North Carolina CME definitions, and that fit within North Carolina's three-year cycle. **Therefore, because of the need to demonstrate relevance, to fit the CME definitions, and to count only those hours earned within your North Carolina three-year cycle, the Physicians Recognition Award and similar awards, taken by**

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themselves, cannot be accepted as documentation.

How Will the Requirement Be Enforced?

A random sample of registrants will be asked to provide documentation of their reported CME at the end of their reporting cycles. Also, those who are called before the Board for informal interviews or for formal action will be asked to provide documentation of their reported CME. **The Board will take appropriate action against those who fail to report completing the CME requirement within a cycle and those who cannot satisfactorily document their CME reports.** Board action will vary depending on the particular circumstances.

What Do I Do If I Have More Questions?

If you have a question not answered here, e-mail us at info@ncmedboard.org. Or:

Fax: 919.326-1130.

Telephone: 919.326-1100.

Write: North Carolina Medical Board
Attention Registration, PO Box 20007
Raleigh, NC 27619.

CME RULE

Title 21 Chapter 32 North Carolina Medical Board

Subchapter 32R - Continuing Medical Education (CME) Requirements

.0101 CONTINUING MEDICAL EDUCATION (CME) REQUIRED

(a) CME is defined as knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public. CME should maintain, develop, or improve the physician's knowledge, skills, professional performance and relationships which physicians use to provide services for their patients, their practice, the public, or the profession.

(b) Each person licensed to practice medicine in the State of North Carolina shall complete no less than 150 hours of practice relevant CME every three years in order to enhance current medical competence, performance or patient care outcome. At least 60 hours shall be in the educational provider-initiated category as defined in Rule .0102 of this Subchapter. The remaining hours, if any, shall be in the physician-initiated category as defined in Rule .0102 of this Subchapter.

(c) The three year period described in paragraph (b) above shall run from the physician's birthday beginning in the year 2001 or the first birthday following initial licensure.

.0102 APPROVED CATEGORIES OF CME

The following are the approved categories of CME

- (1) Educational Provider-Initiated CME:
 - All education offered by institutions or organizations accredited by the Accreditation Council on Continuing Medical Education (ACCME) and reciprocating organizations or American Osteopathic Association (AOA)
 - (a) Formal courses
 - (b) Scientific/clinical presentations, or publications;
 - (c) Enduring Material (Audio-Video)
 - (d) Skill development
- (2) Physician-Initiated CME:
 - (a) Practice based self-study
 - (b) Colleague Consultations
 - (c) Office-based outcomes research
 - (d) Study initiated by patient inquiries
 - (e) Study of community health problems
 - (f) Successful Specialty Board Exam for certification or recertification
 - (g) Teaching (professional, patient/public health)
 - (h) Mentoring
 - (i) Morbidity and Mortality (M&M) conference
 - (j) Journal clubs
 - (k) Creation of generic patient care pathways and guidelines
 - (l) Competency Assessment

.0103 EXCEPTIONS

A licensee currently enrolled in an AOA or Graduate Medical Education (ACGME) accredited graduate medical education program is exempt from the requirements of Rule .0101 of this Section.

.0104 REPORTING

At the time of annual registration immediately following the CME reporting period, each Licensee shall report on the Board's annual registration form the number of hours of practice-relevant CME obtained in compliance with section .0101 of this Subchapter. Records documenting CME hours must be documented by categories for six consecutive years and may be inspected by the Board or its agents. ♦

DataLink

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A special file was also to be added to the Board Action Section of the program listing all physicians whose licenses have been declared "inactive."

To all the staff members at the NCMB who supported the initial concept of the DataLink program, along with the hospitals that have supported and purchased the software, we, as medical staff professionals, would like to say "thank you." DataLink is a very important part of the credentialing process at most North Carolina hospitals. In fact, it would be wonderful if, somehow, the same licensing data, provided by their licensing agencies, could be downloaded into DataLink for the dentists, podiatrists, and optometrists. Maybe this could be a joint venture.

Hospitals Need DataLink

To those hospitals that do not have DataLink, we would say that you are missing out on a great credentialing tool! As more and more hospitals are linked to this program, JCAHO surveyors will expect to see the presence of this software during your survey process. With the new regulations for licensing, if your license information is not computerized, you will have a credentialing nightmare.

Area hospitals have found access to DataLink to be very reliable and the staff at the NCMB have always responded in a prompt and courteous way. The DataLink is considered a primary source verification, and JCAHO surveyors have been impressed with DataLink and the fact that it offers 24-hour access, seven days a week. DataLink is also good for verifying licenses of non-staff physicians that order non-invasive tests or labs or refer a patient to one of your outpatient services.

NCAMSS would like to take this opportunity to say "thank you" to the staff of the NCMB for their help in providing us with DataLink, and for including members of our association as participants in meetings to discuss updates of the software. ♦

North Carolina Medical Board

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"DataLink is a very important part of the credentialing process at most North Carolina hospitals"

The Physician Assistant

Walter J. Pories, MD, Secretary/Treasurer, NCMB
with Laurie Ann Driscoll, PA-C



Dr Pories

Surgeons rarely practice alone. Folks may think of us as Lone Rangers, but we do our best work when we have a colleague across the table. I learned this on my first day on the clinical wards when my older sister, an experienced nurse, told me the

secret of survival, "Stay on the good side of the nurses."

The advice is still sound, but today, it should be expanded to include a newer group of professionals misnamed "physician assistants." They do more than assist; they serve as our ears and eyes, our hands, and often our consciences. They are true colleagues, and we are fortunate to have them at our sides.

In surgery, we teach with stories. Let me, therefore, share a story with you as told by Ms Laurie Driscoll, an excellent physician assistant working in our department here at the Brody School of Medicine at East Carolina University.

I had just walked in the door from work, and the phone was ringing. It was my mother. She called because my father had been having vague abdominal and lower back pain since about noon. It was now 6:00 p.m., and he was not any better. All of this was very unusual because my father has never really been sick, and he rarely complains about aches and pains.

Earlier that day, he had gone to his regular Wednesday morning card game in Fort Pierce, a small town in Florida about 30 minutes from his home. He began having vague, diffuse abdominal cramping around 1:30 p.m.. He played cards until about 4:30 p.m. and then came home. He explained to my mother the pains he was experiencing, and my mother gave him Gas-X. It provided no relief. In addition to his abdominal pain, he also began to have lower back pain, and he complained of having to belch a lot.

After my mother had relayed the entire story, I began asking her some routine questions. "Was there any nausea or vomiting?" "None." "Had he experienced any diarrhea?" "No." "Had he had a normal bowel movement that morning?" "Yes." "Was there any pain or burning upon urination?" "No." "Did he have an appetite?" "None," and he had last eaten

at 11:00 a.m. My mother explained that the only other problem she could tell was that he was "a little clammy."

My father had not been to a doctor in over 20 years. He is a heavy smoker, and he is mildly overweight. Several possibilities of what could be wrong crossed my mind: cholelithiasis or cholecystitis, appendicitis, pancreatitis, early bowel obstruction, a GI virus, or kidney stones. I just was not sure. I finally asked my mother to go to the den, to have my father lie down on the couch, and to get on the phone in the den. When she got back on the line, I explained to her how to divide the abdomen into four quadrants, with the belly button being the center point. I told her to feel the upper right side and push down gently. She did that, and it did not cause any pain. Then she moved down to the right lower area and did the same. Again, this was not uncomfortable. She then went to the left lower quadrant. This area was not tender either, but as she moved her hand up she said, "Charlie, what is this hard lump?" He said he had not noticed anything there. I asked the size and location, and she told me that it was like a baseball to the left of his belly button. She kept feeling it, and then came the dreaded words: "Laurie, it feels like it is thumping... like it has a heartbeat." My heart sank! I knew at this point exactly what he had without a doubt, a large abdominal aortic aneurysm that was obviously leaking and causing the pain in his back and abdomen. I tried to remain calm so I would not scare my mom, but I think she knew it was bad. I told her to take him to the closest hospital right away. I had her write on a piece of paper "pulsatile abdominal mass, left of umbilicus" and give it to whomever she saw first when they got there. Because it would be faster and my father was still talking and able to move around, I told her to drive him to the hospital rather than call and wait for an ambulance.

When they arrived at the emergency room, my mom handed the paper to the nurse. From then on, things moved incredibly fast. The CT, performed even before registration, revealed a 9.2 cm leaking abdominal aortic aneurysm. My father asked to speak to my mother, and a pastor came in to see him, because the surgeon gave a rather grim prognosis. He was in the operating room within 30 minutes. He survived the operation, but he required reintubation 2 days postoperatively and required a total 10 units of

blood. He was discharged 14 days post-operatively and has recovered completely.

It is difficult to write about this even now. I still get tearful when I think about how close he came to dying. I was so close to telling my mother that night to just have him lie down for a while and see if he felt better. But the fact that my dad was complaining of pain, I knew it had to be more than just a "flu." My mother did all the right things to help me determine that it was worse than either of us could have guessed. The pieces, for whatever reason, fell together and allowed my dad to pull through what is generally a fatal situation. We are truly fortunate, and it really is a miracle.

Others have documented the contributions of physician assistants with respect and admiration. Miller et al* demonstrated that physician assistants can be an excellent alternative for a trauma center that does not have surgical residents. In a three-year study of their trauma experience, these trauma surgeons reported that physician assistants saved them 4 to 5 hours per day, reduced patient transfer time from the emergency department, and reduced lengths of stay.

Perhaps the best indicator of the value of this new profession is the recent election of Mr Wayne W. VonSeggen, a practicing physician assistant for more than 20 years, to the presidency of the North Carolina Medical Board. This was not a political process. Mr VonSeggen served as president of the North Carolina Academy of Physician Assistants from 1983 to 1984 and held positions on numerous other committees over the years. Mr VonSeggen was chosen unanimously by a board that is two-thirds physicians – physicians recognizing his administrative skill, his integrity, and his thoughtful judgment.

In the reviews of the surgical advances of the last millennium, we saw many citations on cardiac surgery, transplantation, minimally invasive techniques, and breakthroughs in monitoring. We would like to add another, often overlooked topic, the development of physician assistants and nurse practitioners. We delight in their success and wish them well for at least another century.

* Miller W, Riehl E, Napier M, Barber K, Dabideen H. Use of physician assistant as surgery/trauma house staff at an American College of Surgeons-verified level II trauma center. *J Trauma* 1998; 44:372-376.



LETTERS TO THE EDITOR



Legislation Is the Best Solution to Records Problem

To the Editor: Two articles in the *Forum* recently struck an especially resonant chord, due not only to their content but also their physical proximity by appearing in the same issue (Roufail, WM: HMOs: Have We Painted Ourselves into a Corner? and Watry, AW: Patient Access to Medical Records, both in the *Forum*, 2000; Vol. V, No. 2). While agreeing wholeheartedly with the former, the latter produced serious misgivings.

When decrying the death of traditional private medical practice at the hands of “big business,” HMOs, and the federal government, Dr Roufail tellingly places the blame for Mr Watry’s problem regarding patients’ decreased access to their medical records exactly where it belongs: with the physicians, patients, captains of business, voters, and politicians who either built today’s mismanaged care juggernaut, cheered it on, or simply stood idly by while it grew to monolithic proportions. Mr Watry’s concerns are certainly well-founded, but some of his solutions seem less than optimal considering the climate in which most contemporary physicians must work.

Mr Watry warns against legislation placing a dollar value on medical records, yet here in West Virginia the legislature’s appraisal, years ago, of not more than \$1.00/page for copies of medical records solved many more problems than it created. Interestingly, and probably not coincidentally, this is the same value the market had placed on copies of legal documents, specifically copies of depositions in medical malpractice litigations. Having a statutorily defined value makes physicians’ patient records simply another product in the medical business inventory, another order to be filled and shipped, another source of cash-flow. Certainly, customers are always entitled to purchase products through an open market at a profit to the provider.

As far as his lament about loss of continuity in patient care, Mr Watry surely recognizes that it was literally thrown out with the baby’s bathwater when medical care mega-corporations began employing “independent primary care providers” such as nurse practitioners and midwives, physician assistants, and “doc-in-the-box” physicians who were rotated daily through a pool of storefront clinics in widely-spread locations. Patients

moving down the high-efficiency, maximum production assembly lines of these medical care factories already, in Mr Watry’s words, “are left in the lurch, not knowing who is going to treat them next, who has access to their records, and whether or not their records are in a secure location; and they are left without appropriate mechanisms for getting these records to a new health care provider in order to provide continuity of care.” When he refers to the way things used to be “[i]n days past,” that’s exactly what they are: past, gone, over, history. We now practice within a new paradigm.

Legislation is certainly the best alternative solution to any problems with patient access to medical records, realizing that statutory relief ideally is intended to establish only a minimum legal standard that should be fair to all parties involved. Such legislation should first of all relieve private physicians of eternal responsibility for record maintenance by defining a statute of limitations after which, if there were no subsequent entries, any records, financial or medical, could be safely destroyed without fear of litigation or prosecution.

Secondly, responsibility for medical records should rest with the legally and contractually defined custodian, not necessarily the attending physician. This is already the case with the records of hospitals and corporate care entities, so there’s no plausible argument for maintaining this onus indefinitely on private physicians who sell their practices or retire, nor on their estates and survivors when they die. The office records are simply another asset purchased in the deal or listed in the estate and should carry no greater responsibility for their maintenance.

While legislation presents the imposition of a minimum standard, it is obvious that almost all physicians in private practice will operate their businesses to a higher standard out of respect for traditional medical ethics and responsibilities. Lawyers, government administrators, and insurance companies should be charged the maximum allowable by law for their requested records, yet patient and collegial requests will almost always be honored *pro bono*. I personally still maintain all records, both financial and medical, of every visit of every patient ever seen in my private practice. Although sometimes involving repeated requests and voluminous documents, no patient has ever been directly charged for copying and mailing her records.

Over the years, many colleagues in private practice have either moved, retired, or died, and almost all their patients have been notified by newspaper advertisements or direct mail regarding where their records would be transferred (usually another local physician’s office) or a date until which records would be transferred at no charge upon patient request to a physician designated by the patient, afterward allowing destruction of untransferred originals.

While there is never an ideal solution to any problem that will completely satisfy all parties, patients who opt to continue their care within the traditional private practice of medicine will have fewer complaints and these can be easily addressed through state medical licensing boards and local medical societies existing mechanisms. For the rest, legislation already insures fair treatment to all participants in various business transactions by clearly defining rights and responsibilities of each without imposing unreasonable burdens upon any. It will do the same in the medical marketplace.

William D. Daniel, MD, FACOG
Executive Director, American Society
of Forensic Obstetricians and
Gynecologists, Buckhannon, WV

Response

Thank you for your letter. We appreciate your insight and commentary. I have this skepticism (perhaps unfounded) that when issues like this are brought to a legislative agenda there is exposure to getting more than you bargained for.

For example, no one would reasonably argue that our government should not have open records and citizens should not have access to them. I am aware of one state, however, that mandates open records must be provided in three working days. Thus, the response to an open records request becomes a higher priority to the agency than its other legislative mandate (medical licensure) that has no time limits imposed on how quickly someone is licensed or disciplined.

Your points provide balance to my argument and I thank you for them.

Andrew W. Watry, Executive Director
North Carolina Medical Board

And More on Medical Records

To the Editor: The article Patient Access to Medical Records written by the Board’s executive director, Andrew W. Watry, MPA,

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Letters to the Editor

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in No. 2, 2000, of the *Forum*, presents the North Carolina Medical Board's position regarding charges for copying and postage of patient records incorrectly.

Mr Watry states in his article: "Another situation we see with increasing regularity is the physician holding records until payment is made for an unsettled account or for the copying of the records themselves. This is contrary to the Board's position statement on medical records." Mr Watry goes on to say that "maintaining and keeping files is a cost of doing business, . . ."

The NCMB Position Statement, as amended 9/1997, says, "The physician may charge a reasonable fee for the preparation and/or the photocopying of the materials." This clearly contradicts the notion that copying and mailing is free to the recipient or "a cost of doing business" to the practice.

I support the policy given in the 1997 NCMB Position Statement. While there is little room for debate that maintaining and keeping files for the purpose of patient care within the practice has long been universally accepted as a cost of doing business, the expense of copying, handling, and postage of records for transfers has not been universally accepted. Furthermore, adding to the long list of documents, forms, and records that are furnished at "no additional charge" is beyond the pale. Indeed, many services, so considered in the past, may now need reconsideration. Faced with the choice of allocating scarce personnel and other resources to the task of preparing and transferring 2/3-year-old medical records or caring for the patients at hand, I have little doubt how healthcare providers should prioritize tasks. If forced to do otherwise, I fear the quality of care might be threatened. It might make more sense to encourage physicians, attorneys, insurance companies, employers, and the myriad of others requesting "All Medical Records" to limit their requests in both number and scope. Paying their way would be a step in that direction. After all, cost shifting is just about a thing of the past!

G. David Dyer, MD
Wrightsville Beach, NC

Response

Thank you for your letter. The premise of your argument seems to be that when I refer to "maintaining and keeping files is a cost of doing business. . ." I am suggesting that these copying and mailing costs should be free to the recipient. I respectfully disagree for two reasons.

(1) I am not aware of anyone in business who assumes that a "cost of doing business" should be free to a recipient. These costs are almost always passed to customers in one form or another. There is no free lunch.

(2) You terminated my quote at a place that takes the sentence out of context. The whole sentence was: "Maintaining and keeping files is a cost of doing business, and it is recognized that in many businesses it is acceptable to withhold services until fees are paid. For the most part, this is not so in medicine." This is not advocacy for furnishing records at no charge. There is a big difference. I go on in the article to state options, such as collection agencies. I am trying to help physicians and their patients avoid a major quicksand pit when medical records are held for payment of a fee. Imagine a physician defending himself or herself in a courtroom for not sending a mammogram to an oncologist because a fee had not been paid yet, compromising continuity of care. How do you think a jury would rule?

Thank you for your comments. We are at your service if we may assist you in any way.

Andrew W. Watry, Executive Director
North Carolina Medical Board

Male Victimization

To the Editor: Regarding the Special Topic: Domestic Violence [by Laura A. Queen] that you published in the Number 2, 2000, issue of the *Forum*, I applaud your intent in bringing this important issue to print, but I must point out that the victims of domestic violence are not always female. In fact, there have been cases, though rarely reported, of males/husbands who were victims of violence perpetrated by women in the household/wives.

Of all the printed material and conferences on domestic violence, I have yet to see or hear any mention of male victims. Though almost never reported, male victims do exist. And I think it would serve to generate more feedback if every presentation on domestic violence made mention of male victimization.

Thank you for disseminating this viewpoint.

Frank Y. Yang, MD, FACS
Pinehurst, NC

Response

*We appreciate your comment and the thoughtful view you bring forward. We hope you will note Ms Queen's second article, which appears in this number of the *Forum*, titled *Battered Men: Another Story*.*

The Editor ♦

Vital Information Required by the NCMB

When a physician or physician extender dies or legally changes name by marriage, divorce, or other legal means, that information is vital to the North Carolina Medical Board to ensure the accuracy and completeness of its records and to effectively serve the interests of its licensees and the public. Copies of the legal documents relating to those events are also needed to add to the appropriate files.

When a licensee dies, a copy of the death certificate should be sent to the Board as soon as possible. When a licensee marries and thereby changes name, a copy of the marriage certificate, showing the name change, should be forwarded to the Board. In the case of divorce, if the decree contains the resumption of a maiden or previous name, copy of the decree should also be sent to the Board. When a licensee's name is changed by any other legal means, the relevant legal document(s) should be sent to the Board.

It is important to note that without the legal documentation the necessary changes cannot be made to the Board's records, and that will result in incorrect names on registration forms, incorrect verifications of license, and misinformation should a licensee be deceased.

This vital information, and the supporting copies of relevant documents, should be sent to the following address: North Carolina Medical Board, Attention: Ms Ann Norris, PO Box 20007, Raleigh, NC 27619. ♦

REVIEW

Doctor Death: The Ultimately Impaired Physician

W. Benson Harer, Jr, MD, President
The American College of Obstetricians and Gynecologists



Dr Harer

"When a doctor goes wrong he is the first of criminals. He has nerve and he has knowledge."

Sir Arthur Conan Doyle
The Speckled Band, 1891

One of the earliest known serial killers was Thomas Neill Cream, MD, hanged 15 November 1892 at age 42 years for the murder (by surreptitiously giving them oral arsenic represented as legitimate medication) of four London prostitutes. Cream most likely was responsible for the premeditated murders by poisoning, either with arsenic or chloroform, of at least five others in North America, including his Canadian wife and four of his U.S. patients, in addition to untold London prostitutes. One of his patients so dispatched was a paramour's elder husband and Cream intended to subsequently profit from an unsuccessful blackmail scheme, threatening the victim's pharmacist with being revealed as the poisoner. Cream was much more successful at murder than extortion or blackmail.

Born 27 May 1850 in Glasgow, Scotland, Cream emigrated with his family to Montreal, Canada, in 1854, where his father prospered in business and young Thomas taught Sunday school. In March 1876, he received, after four year's study, the MD degree from Quebec City's McGill College, presenting his graduation thesis on the pharmacological properties of chloroform. The occasion's speaker addressed the graduates on "The Evils of Malpractice in the Medical Profession."

Shortly after his graduation and prior to sailing for England to continue his medical

education at St Thomas's Hospital, London, Cream's fiancée became ill and her father discovered she was experiencing complications of a recently induced abortion performed by person or persons unknown, assumed to be Cream. A literal "shotgun wedding" was quickly performed before Cream's embarkation, but less than a year later the newly wed Mrs Cream died following a short illness with suspicious symptoms which were treated with pills mailed by her husband from London.

During his studies at St Thomas's, Cream was exposed to Dr Albert James Bernays, professor of chemistry and a medical expert witness for the Crown Prosecutor in a high-profile trial charging murder by strychnine poisoning. The case had been difficult to solve due to the lack of uniformity in British coroner inquest law, the prestigious British Medical Journal opining that as a result many violent deaths by poisoning were probably going uninvestigated.

Cream also took advanced training in obstetrics at St. Thomas's while Lister sprayed carbolic acid around the operating rooms at nearby General Lying-In Hospital, but in 1877 the young Canadian obstetrician failed his anatomy and physiology entrance examinations for the Royal College of Surgeons. The following year, he was admitted to the Royal Colleges of Physicians and Surgeons, Edinburgh, with a midwifery license and in May returned to London, Ontario, where he opened an obstetrical practice. Following the death of a patient from an overdose of chloroform suspected to have been employed as an anesthetic for elective abortion (her body was discovered in the outhouse behind his office), Cream hastily crossed the border to Chicago and was licensed by the Illinois State Board of Health in August 1879, promptly opening a medical office in the city's busy red light district.

Cream had long been known as a womanizer and frequent consort of prostitutes, and it was common knowledge he provided abortions. Another patient was discovered dead and decomposing in a rooming house, apparently following postabortal sepsis.

Arrested and charged with murder, Cream was acquitted primarily due to the skill of his defense attorney and the fact that the state's only witness was a "colored" lay midwife who occasionally assisted him. After the death of a third female patient under suspicious circumstances, failed blackmail and extortion schemes, a sordid libel attempt, and the recent poisoning of his cuckold patient noted above, Cream hurriedly left Chicago and returned to Canada.

Within a month, he was arrested in Belle Riviere, Ontario, taken to Windsor for questioning, and extradited to Chicago to stand trial for the murder of his mistress's husband. He was again tried for murder, this time convicted in September 1881 and sentenced to life imprisonment in Joliet State Prison with at least one day a year to be spent in solitary confinement. Ten years later, Illinois Governor Joseph W. Fifer granted Cream executive clemency with release in July 1891.

Returning to Canada and collecting a modest inheritance, Cream then set sail again for London where he took rooms across the street from St. Thomas's Hospital but never again practiced medicine in the traditional sense. He did represent himself to acquaintances and potential victims as a physician, even offering pills he compounded himself for their various symptoms. Cream quickly became a frequent customer of the many prostitutes working nearby, claiming multiple sexual encounters in an evening, and was known to be obsessed with pornography. He also became a regular user of opium, morphia, cocaine, and beverage alcohol to excess.

Following the deaths of two prostitutes shortly after being seen with Cream, he once more left town and sailed to Canada, but returned to London after three months and again took lodgings among its prostitutes in the entertainment district. Two more of his female acquaintances subsequently died of arsenic poisoning. On 3 June 1892, he was arrested by Scotland Yard on charges of

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Review

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blackmail, on 18 July charged with murder in the deaths of four prostitutes, during 17-21 October tried by the Crown in Old Bailey court rooms, on 21 October found guilty after ten minutes' deliberation by a jury of his peers, immediately sentenced by the presiding judge to be hanged by the neck until dead and God's mercy invoked on behalf of his soul, and executed 15 November at Newgate Prison.

A Prescription for Murder: The Victorian Serial Killings of Dr. Thomas Neill Cream
Angus McLaren

University of Chicago Press, Springer-Verlag, Chicago, IL, 1993
233 pages (illustrated), \$12.95 paperback

In the finest police tradition, Scotland Yard took full credit for the investigation and arrest, yet McLaren clearly shows it was Cream's own hubris in calling attention to the murders (first officially dismissed as suicides or food poisonings), coupled with the prostitute community's coordinated and persistent efforts to protect itself, that led to his capture. McLaren has not written a deep, psychological analysis of the serial murderer's criminal mind but instead an historical and social analysis of moral, economic, and political conditions during the late 1800s which fostered or at least allowed Cream's professional failure, ever-deepening descent into moral degradation, and eventually prolonged macabre crime spree.

The author examines quite well the role society then demanded for women in general, prostitutes in particular, and the subsequent changes in its views of crime, law enforcement, and the judicial system regarding punishment of criminals and the status of women. Since God dictated the Ten Commandments to Moses, murder has been recognized as the ultimate crime against persons, with, over the last 150 years, serial killers filling a special niche. Prostitutes have always comprised a remarkably large number of their victims. Undoubtedly, society's attitudes toward commercialization of sex in general and prostitutes in particular have made their victimization much easier.

The first half of McLaren's book, summarized above, is a straightforward factual account of Cream's life, such as it was. It avoids sensationalism, conjecture, and interpretation as much as possible while holding the reader's attention with its well-written

historian's commitment to detail and chronology. One shouldn't be surprised, as McLaren, professor of history at the University of Victoria, Vancouver, British Columbia, is an established author on scholarly topics both historical and social.

The second half is less like a yellowed, dog-eared copy of an old *Police Gazette* or *New York Daily News*, more interesting and intellectually challenging as McLaren skillfully reweaves the fabric of life at the turn of the century. That era's women tried to control their fertility by using contraceptives or seeking elective abortions, while various moral and legal authorities simultaneously tried to either aid or frustrate such efforts. He describes law enforcement's progression from apprehension of criminals after the fact to surveillance of potential perpetrators, crime prevention, and, finally, actually promoting crimes through enticement and entrapment in order to make arrests. He also explains how, during the late 1800s, revolutions in cheap communication and transportation, such as widely distributed periodicals, reliable public mails, anonymous post office box addresses, mimeographs, plus fast steamships and trains, made both legitimate and illegal activities more easily and efficiently conducted. One hundred years later, satellites, personal computers, the Internet, and jet aviation have remarkably done the same during the last 20 years of our century.

Suffragettes and other activists fighting for the electoral, personal, legal, and property rights of women, both married and single, threatened an already unstable status quo. Other studies of late 19th-century society have focused on England, but Cream's exploits in Canada and the U.S. give us a distinctly American view of similar problems for women on this side of the Atlantic. Devout feminists will find much for justified outrage here.

Our concepts of criminal behavior, motivation, genesis, control, punishment, and rehabilitation remain even today far from providing effective preventatives. Disparities in legal and societal status of women remain with us, as do prostitution and exploitation. Women, especially prostitutes, continue to be the prime victims of murderers, rapists, assaulters, batterers, muggers, and other violent criminals, with little protection except what they themselves provide. Control of their sexuality and fertility remains hotly and sometimes violently contested. Serial murderers continue to own the headlines on occasion. McLaren contends that Cream and his crimes are best understood as the products of an already sick Late Victorian society and he won me over with his arguments. Other readers may find alter-

nate explanations.

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Reprinted with permission from *The Medicolegal OB/GYN Newsletter* of The American Society of Forensic Obstetricians and Gynecologists, PO Box 536, Buckhannon, WV 26201-0536.

Editor's Note: The end of the 19th century saw still another medical monster in the person of Herman Webster Mudgett, who renamed himself Harry Howard Holmes. Born in Gilmanton, New Hampshire, in 1860, and trained at the University of Michigan Medical School, he was to become the first, and possibly the worst, identified serial killer in U.S. history. When finally caught, he admitted to killing 28 people, but estimates are that he murdered, and often mutilated, over 200, mostly young women. He was hanged in Philadelphia on May 7, 1896.

The end of the 20th century seems to have joined the end of the 19th century in *fin de siècle* horror. The crimes of Drs Cream and Mudgett/Holmes have been echoed in the careers of Britain's Dr Harold Shipman and our own Dr Michael Swango. Dr Shipman was sentenced in January 2000 to 15 terms of life in prison for injecting elderly female patients with fatal doses of heroin between 1995 and 1998. British police estimate that he may have killed as many as 200 patients in the same way over his 30 year career. That would make him the worst serial killer in British history.

Dr Michael Swango was immediately arrested by New York authorities after his recent release from prison, where he had been serving time for lying on an application for a position at a VA hospital. In early September, he pled guilty to five felonies, and admitted murdering four of his patients through lethal injection and attempting to kill four more. He was sentenced to three consecutive life terms without possibility of parole. He is suspected of murdering 60 or more patients during his medical career, which spanned 15 years and took him from Illinois, to Ohio, to Virginia, to South Dakota, to New York, and then to Zimbabwe. He was on his way to another hospital job, this time in Saudi Arabia, when he was arrested in Chicago in 1997. His story is told in chilling detail in James Stewart's book *Blind Eye*.

Sir Arthur Conan Doyle, a physician himself, had it right. ♦

Explore the NCMB's Web Site:

www.ncmedboard.org

The North Carolina Medical Board's Web site, www.ncmedboard.org, is a straightforward, content-based (no distracting bells and whistles) source of useful information for the public, licensees, the media, and anyone else interested in the Board and its work. The Site Map below is featured on the Web site and presents an easy to use guide to the topics covered on the site. Simply click on the Site Map bar in the menu at the top of the home page, find the item you want on the map, then click – you'll be there. Exploration couldn't be easier. Among other things, you'll find forms that can be easily printed, the *Forum* and other publications, an electronic license registration system, information about individual licensees, lists of current and past disciplinary actions, and details about the Board and its operation.

Improvements are being made continually to the Board's site. New features and new information are added regularly. We hope you'll explore the site, using the Site Map as your guide, and take advantage of the resources it makes available. And, please, e-mail us your comments and reactions (public.affairs@ncmedboard.org).

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- [License Numbers Issued September 23, 2000](#)

Complaints

- [Complaints System](#)
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Disciplinary & Other Board Actions

- [Board Action Report for 1999](#)
- [Bimonthly Disciplinary Reports](#)
- [Immediate Disciplinary Notices](#)

The Forum & Other Resources

- [The Forum](#)
- [Board Brochure](#)
- [Video & Audio Programs Available](#)

Professional Corporations & Professional Limited Liability Companies

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NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

May-June-July 2000

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

A term used for this report to indicate restrictions or requirements placed on the licensee/licensee.

Consent Order:

An order of the Board and an agreement between the Board and the practitioner regarding the annulment, revocation, or suspension of the authorization to practice or the conditions and/or limitations placed on the authorization to practice. (A method for resolving disputes through informal procedures.)

Denial:

Final decision denying an application for practice

authorization or a motion/request for reconsideration/modification of a previous Board action.

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

Immediate temporary withdrawal of the authorization to practice pending prompt commencement and determination of further proceedings. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

License to practice medicine for a specific period of time. Often accompanied by conditions contained in a Consent Order. May be issued as an element of a Board or Consent Order or subsequent to the expiration of a previously issued temporary license.

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

The practitioner's relinquishing of the authorization to practice pending an investigation or in lieu of disciplinary action.

ANNULMENTS

NONE

REVOCATIONS

NONE

SUSPENSIONS

See Consent Orders:

COBB, Timothy Lee, Physician Assistant

GROGAN, Patricia Jo, MD

ZABENKO, Robert Tracy, DO

SUMMARY SUSPENSIONS

NARA, David Alan, MD

Location: Hancock, MI

DOB: 4/28/1960

License #: 0000-39450

Specialty: GP (as reported by physician)

Medical Ed: Michigan State University (1986)

Cause: Dr Nara may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material within the meaning of the statute.

Action: 6/14/2000. Order of Summary Suspension of License issued, effective on delivery of the Order to Dr Nara. [Notice of Charges and Allegations issued on 6/14/2000 alleging summary suspension of Dr Nara's medical license by the Michigan Board based on allegations of alcohol abuse and self-prescribing of controlled substances for other than lawful purposes.]

CONSENT ORDERS

COBB, Timothy Lee, Physician Assistant

Location: Yuma, AZ

DOB: 11/20/1948

License #: 0001-00183

PA Education: Duke University (1977)

Cause: Pursuant to an Agreed Order of 4/30/1999, the Texas PA Board indefinitely suspended Mr Cobb's Texas license based on his diversion of certain controlled substances and his conviction for felony fraudulent delivery of a prescription for a nonmedical purpose. On 10/22/1999, the Texas Board stayed suspension of his license for 10 years on terms and conditions.

Action: 6/15/2000. Consent Order executed: Mr Cobb's North Carolina PA license is suspended indefinitely; that suspension is stayed for 10 years on condition he comply in all respects with the Texas Agreed Order of 10/22/1999; must comply with other conditions.

COHN, Gerald Herbert, MD

Location: Seattle, WA

DOB: 11/19/1928

License #: 0000-38916

Specialty: N/PD (as reported by physician)

Medical Ed: State University of New York, Upstate (1953)

Cause: On 12/19/1997, while preparing to perform a lumbar puncture, Dr Cohn discharged into the face and eye of an observer a syringe containing lidocaine through a needle that had just been withdrawn from the back of a patient. Dr Cohn asserted the discharge was accidental. Certain circumstantial evidence suggests the act was intentional, while other circumstantial evidence suggests it may not have been. Dr Cohn admits that if the Board found the act was intentional, that would be immoral or dishonorable conduct and unprofessional conduct. He has met with the Board, has been cooperative, and has seemed genuinely remorseful for the damage his conduct caused. He no longer performs lumbar punctures and will not do so in future unless all persons present take adequate safety measures to protect against injury and transmission of communicable disease.

Action: 5/12/2000. Consent Order executed: Dr Cohn is reprimanded.

GALEA, Lawrence Joseph, MD

Location: Charlotte, NC (Mecklenburg Co)

DOB: 10/19/1948

License #: 0000-27046

Specialty: FP/GP (as reported by physician)

Medical Ed: University of Cincinnati (1980)

Cause: To amend the Consent Order of 8/23/1999 by which Dr Galea's license was reinstated after having been inactive [for failure to reregister]. The Board summarily suspended Dr Galea's license and, thereafter, entered into a Consent Order with him in December 1991, which was amended in September 1992. He was relieved of that Consent Order by a Board Order in May 1993. [Details of the earlier actions are available from the Board.] The Board has agreed to modify the current Consent Order to take account of his present practice and to make certain requirements more specific.

Action: 7/21/2000. Consent Order executed: Dr Galea is issued a license to expire on the date shown on the license (1/31/2001); he shall submit to and cooperate with a psychological evaluation and cause a report of that evaluation to be received by the Board by 10/01/2000; nothing in this Consent Order prohibits or limits the Board from taking any lawful action based on the results of the evaluation; he shall renew his contract with the NCPHP and abide by its terms; he shall maintain his NCPHP contract until the Board orders otherwise; he shall have a female chaperon present during all of any encounter he has with a female patient and the chaperon shall sign and date each patient's chart, noting her presence during the encounter; he shall not supervise PAs, NPs, or nurse midwives in any way; he shall obtain 50 hours of relevant CME each year, 30 hours of which must be in Category I; must comply with other conditions. The terms and conditions in this Consent Order supersede those in the 1999 Consent Order imposing any continuing obligation or condition on Dr Galea, except those imposing a reprimand and regarding the public nature of the Consent Orders.

GOUBRAN, Michel Zaki, MD

Location: Durham, NC (Durham Co)

DOB: 2/15/1935

License #: 0000-21039
 Specialty: OBG (as reported by physician)
 Medical Ed: University Ein Shams, Egypt (1962)
 Cause: Dr Goubran admits and the Board finds Dr Goubran's license was suspended indefinitely pursuant to the Board's Order of April 27, 2000; the Board's Order permits a stay of all but the first six months of the suspension if Dr Goubran executes a consent order with certain terms and conditions; Dr Goubran desires to enter into this Consent Order and thereby stay the suspension imposed by the Board's Order.
 Action: 5/24/2000. Consent Order executed: Dr Goubran admits the findings of fact and conclusions of law set forth in the Board's Order, except he denies the stapling [of the medical student's finger] was done intentionally; within 60 days of this Consent Order, Dr Goubran shall obtain an assessment from the NCPHP and cause a copy of the assessment to be sent to the Board; within one year, he shall obtain at least 40 hours of CME in the areas of epidemiology and infectious disease prevention, to be approved in writing by the Board's president; within one year, he shall attend and successfully complete a sensitivity training course, to be approved in writing by the Board's president; must comply with other conditions.

GROGAN, Patricia Jo, MD

Location: Smith River, CA
 DOB: 7/05/1954
 License #: 0000-34020
 Specialty: P (as reported by physician)
 Medical Ed: State University of New York, Brooklyn (1985)
 Cause: This matter regards Dr Grogan's interaction with patients. Dr Grogan's license is currently inactive and she is not interested in reactivating her registration; during the times relevant to this matter, she practiced in Pinehurst, NC. The Board received a complaint from a patient that Dr Grogan engaged in various boundary violations with the patient. These violations included Dr Grogan having dinner with the patient in a restaurant and afterwards the patient spending the night on Dr Grogan's couch; they also interacted socially at Dr Grogan's invitation and Dr Grogan disclosed personal information to the patient, changed shirts in front of the patient in a public place, allowed the patient to help clear her van and garage, and told the patient to call her Patti. Dr Grogan denies some of this. Another patient complained concerning other boundary violations: repeated requests by Dr Grogan that the patient interact socially with her and her children, a request that the patient come to Dr Grogan's house to administer homeopathic remedies to Dr Grogan for an abscessed tooth, Dr Grogan accepting \$120 from the patient so she could obtain dental care, Dr Grogan prevailing on the patient to search the Internet for prospective buyers for her medical practice, Dr Grogan drinking beer during treatment sessions, and Dr Grogan calling the patient at home to ask advice about personal problems. Dr Grogan denies some of this. Dr Grogan admits she wrote a letter to the referring physician's office administrator in which she disclosed confidential information about the first patient without permission. She also admits she nursed one of her children in front of male and female patients during various treatment sessions; although at the time she believed the patients consented to her doing this, she now understands that it was unprofessional even if they consented. She also admits she hired another patient to work in her office as an administrative assistant.

Action: 6/22/2000. Consent Order executed: Dr Grogan's license is suspended for 60 days and the suspension is stayed for one year on the following terms and conditions. Dr Grogan shall establish a counseling relationship with an appropriate person whose practice relates to boundary issues and who is acceptable to the Board, and she shall authorize that person to report to the Board quarterly for the 12 month period in which this matter is suspended; Dr Grogan shall meet all requirements set by her counselor; she shall return to North Carolina to meet with a panel of the Board as often as required by the Board, but no less than two times, to report on her progress in setting proper physician-patient boundaries; this Consent Order shall remain in effect for 12 months.

KONG, Lok King, MD

Location: Murphy, NC (Cherokee Co)
 DOB: 5/28/1938
 License #: 0000-22585
 Specialty: OBG (as reported by physician)
 Medical Ed: National Taiwan University (1969)
 Cause: Dr Kong has retired and suffers from poor health. On 2/26/1996, the New York Board issued an order through which

Dr Kong's New York license was censured and reprimanded, and his New York license was put on probation for a period to begin if and when he resumes practice in New York. He has not been disciplined in North Carolina.

Action: 7/20/2000. Consent Order executed: Dr Kong's North Carolina medical license is placed on inactive status. [A copy of the Notice of Charges and Allegations filed against Dr Kong by the North Carolina Board in September 1999, which contains a copy of the New York record, is available on request.]

McCLELLAND, Scott Richard, DO

Location: Camp Lejeune, NC (Onslow Co)
 DOB: 7/19/1948
 License #: 0000-29064
 Specialty: P (as reported by physician)
 Medical Ed: Kirksville Osteopathic College (1980)
 Cause: Matter considered at Dr McClelland's request and on the Board's own motion regarding charges that Dr McClelland engaged in professional sexual misconduct. During the relevant period, Dr McClelland was division surgeon for the 2nd Marine Division, II Marine Expeditionary Force, Camp Lejeune, NC, and worked as a psychiatrist at Camp Lejeune Naval Hospital. In March 2000, he was charged with violating five articles of the Uniform Code of Military Justice stemming from his work at the Naval Hospital. Among other things, the charges allege he engaged in sexual misconduct with one or more female patients. It is agreed that further proceedings before the Board should be postponed until final resolution of the military charges against Dr McClelland, subject to the conditions of this Order.

Action: 6/22/2000. Tolling Agreement and Order executed: Dr McClelland shall not practice in North Carolina until the Board orders otherwise; no such order shall be issued until the military charges are resolved and Dr McClelland has appeared before the Board or members of the Board for an informal interview; the Board shall not conduct further proceedings on these matters until the military charges are resolved; Dr McClelland must comply with other conditions.

RIDDLE, William Mark, MD

Location: Stokes, NC (Pitt Co)
 DOB: 3/20/1956
 License #: 0000-39871
 Specialty: FP/EM (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1985)
 Cause: Dr Riddle requests reinstatement of his license. He first surrendered his license in September 1997 after he was confronted about his diversion and abuse of a controlled substance. He was issued a temporary license with various conditions through a consent order of October 1998, which was amended in September 1999. He surrendered his license again in November 1999 after he was confronted about violating the September 1999 consent order by self-prescribing a controlled substance and by working more than the 40 hours a week the consent order stipulated. Since surrendering his license, he has been working as a case manager with Virginia Monitoring, an organization that monitors compliance of Virginia practitioners recovering from alcohol and/or substance abuse. He has met regularly with an addiction specialist to discuss the causes of his relapse and formulate a stronger relapse prevention plan. He reports he has not consumed alcohol or prescription medication not prescribed for him by someone else since November 1999, and the NCPHP reports he has fully complied with his contract with the NCPHP since that time. Virginia Monitoring and the addiction specialist report they have screened him regularly and all tests for alcohol and drugs have been negative. He has also been actively involved in AA and Caduceus.

Action: 6/14/2000. Consent Order executed: Dr Riddle is issued a license to expire on the date shown on the license [9/30/2000]; he shall practice only in a setting approved by the Board's president; he may not work more than 30 hours per week; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA, NA, and Caduceus meetings as recommended by NCPHP; he shall not attempt to reregister or obtain a registration to prescribe controlled substances without written endorsement from the Board; he shall not purchase, administer, prescribe, dispense, or order

any controlled substances; he may not supervise PAs or NPs in any way; he shall obtain and document 50 hours of Category I CME relevant to his practice each year; he shall provide a copy of this Consent Order to all current and prospective employers; must comply with other conditions.

WASHINGTON, Clarence Joseph, III, MD

Location: Fayetteville, NC (Cumberland Co)

DOB: 1/11/1947

License #: 0000-32295

Specialty: GYN (as reported by physician)

Medical Ed: University of Michigan (1974)

Cause: In May 1999, Dr Washington was found guilty in federal court of willfully failing to make an income tax return for 1994 and 1995 and was sentenced to 20 months imprisonment. He voluntarily reported his conviction to the Board and, pursuant to a Consent Order of 8/27/1999, the Board suspended his license. He served 10 months at the Federal Correctional Institution in Morgantown, WV, and has now been released. Since his conviction, he has received counseling to help him administer his business affairs and professional plans. He recognizes his lack of attention to personal business affairs led to his failure to make timely income tax returns. While in prison, he maintained his medical knowledge by obtaining 130 hours of relevant Category I CME. He has informed the Board of his employment possibilities and his plan to provide volunteer health care on a pro bono basis to indigent care clinics. Several of his potential employers have written the Board that they are aware of his legal problems and that they support his return to practice. Since his release, Dr Washington has spent time accompanying a fellow physician in his office as preparation for a return to practice.

Action: 7/31/2000. Consent Order executed: Dr Washington shall surrender his license and the Board shall issue him a license to expire on the date shown on the license [1/31/2001]; he shall obtain an evaluation from the NCPHP and follow any recommendations of the NCPHP; he shall keep the Board advised of his progress in maintaining complete and accurate business records twice each year; twice each month he shall attend OB/GYN rounds at UNC or Duke; he shall obtain and document 50 hours of relevant Category I CME each year; must comply with other conditions.

ZABENKO, Robert Tracy, DO

Location: Fort Bragg (Cumberland Co)

DOB: 12/05/1958

License #: 0098-00166

Specialty: OBG (as reported by physician)

Medical Ed: University of Health Sciences, College of Osteopathic Medicine, MO (1994)

Cause: From July to November 1999, Dr Zabenko engaged in a number of boundary violations with a patient, including e-mailing and telephoning her for nonmedical reasons and socializing with her. From November through December 1999, Dr Zabenko and the patient engaged in a sexual relationship while the physician-patient relationship still existed between them. In December 1999, Dr Zabenko obtained an assessment at the Behavioral Medicine Institute of Atlanta. From January through March 2000, he attended and successfully completed eight weeks of cognitive-behavioral treatment at BMI, with a relapse prevention component. He has continued treatment since that time and has signed a contract with the NCPHP. He did not practice from December 15, 1999, through March 26, 2000.

Action: 6/15/2000. Consent Order executed: Dr Zabenko's license is suspended from December 15, 1999, through March 26, 2000; he is reprimanded for his boundary violations with his patient, including the sexual relationship; he shall ensure a female chaperone who has read this Consent Order is present when he examines female patients; the chaperone shall document she was present and that no boundary violations or other misconduct occurred; he shall post a copy of the Principles of Medical Practice on his office, examination room, reception area, and other walls where it can be easily read by his patients; each month he shall ask three members of this staff who have read this Consent Order to complete a Staff Surveillance Form, which shall be forwarded by the office manager to his therapist for inclusion in the therapist's quarterly reports to the Board; during one week each month, he or his staff will ask all patients seen to complete a Patient/Patient's Family Satisfaction Survey, which shall also go to his therapist for inclusion in the report to the Board; at his own expense, he shall undergo a polygraph examination every six months to determine if he has been involved in sexual misconduct with his patients or female staff and the results shall be sent to his therapist for inclusion in the report to the Board; he shall continue his relapse prevention therapy with his

current therapist or another approved in writing by the president of the Board and he shall comply with all recommendations made by the therapist regarding his practice; Dr Zabenko shall direct his therapist to provide quarterly reports of his progress to the Board; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

DENIALS OF LICENSE/APPROVAL

MITCHELL, John B., Physician Assistant

Location: Fayetteville, NC (Cumberland Co)

DOB: 9/21/1950

License #: 0001-02471

PA Education: Academy of Health Sciences (1977)

Cause: The Board is not satisfied Mr Mitchell has the requisite good moral character expected of a PA in that he may have committed boundary violations in his interactions with patients and office staff. A review of his interactions with patients and staff also indicates he failed to follow instructions from his supervising physician, violated patient confidences, misdiagnosed a medical condition, chose inappropriate treatments in caring for patients, and prescribed an unsuitable medication on at least one occasion.

Action: 5/17/2000. Application for PA license denied. Mr Mitchell is entitled to a formal hearing on this matter if he requests such within 10 days of receiving this written notification of denial.

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

SURRENDERS

ANDRINGA, Richard Cornell, MD

Location: Greensboro, NC (Guilford Co)

DOB: 12/23/1946

License #: 0000-20463

Specialty: AN/PD (as reported by physician)

Medical Ed: University of Wisconsin (1974)

Action: 7/20/2000. Voluntary surrender of North Carolina medical license.

BARNES, James Allan, Jr, MD

Location: Newton, NC (Catawba Co)

DOB: 2/09/1958

License #: 0000-39540

Specialty: OB/GYN (as reported by physician)

Medical Ed: Marshall University (1987)

Action: 5/18/2000. Voluntary surrender of North Carolina medical license.

CROMER, William Browning, MD

Location: Kinston, NC (Lenoir Co)

DOB: 11/16/1931

License #: 0000-10448

Specialty: GP/OS (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1956)

Action: 5/02/2000. Voluntary surrender of North Carolina medical license.

POTOCKI, Lance Dewitt, MD

Location: Edenton, NC (Chowan Co)

DOB: 9/24/1952

License #: 0000-29374

Specialty: FP (as reported by physician)

Medical Ed: University of Maryland (1981)

Action: 7/01/2000. Voluntary surrender of North Carolina medical license.

SHAFTNER, Kimberly K., MD

Location: Princeton, NC (Johnston Co)

DOB: 12/09/1954

License #: 0000-25426

Specialty: FP/AN (as reported by physician)

Medical Ed: Ohio State University (1980)

Action: 5/08/2000. Voluntary surrender of North Carolina medical license.

TOLLESON, Thaddeus Rex, MD

Location: Durham, NC (Durham Co)

DOB: 11/10/1966

License #: 0097-01175

Specialty: IM/C (as reported by physician)

Medical Ed: University of Texas, Houston (1993)

Action: 5/23/2000. Voluntary surrender of North Carolina medical license.

See Consent Orders:

WASHINGTON, Clarence Joseph, III, MD

CONSENT ORDERS LIFTED

COLLINS, Natalear Rolline, MD

Location: Franklinton, NC (Franklin Co)
 DOB: 10/22/1955
 License #: 0000-27108
 Specialty: GP/FP (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1981)
 Action: 7/10/2000. Order issued lifting Consent Orders of 10/10/1997, 2/07/1997, and 8/09/1996.

ENGLEMAN, James Donald, Jr, MD

Location: Vanceboro, NC (Pitt Co)
 DOB: 4/05/1960
 License #: 0000-32696
 Specialty: FP (as reported by physician)
 Medical Ed: University of Louisville (1985)
 Action: 7/10/2000. Order issued lifting Consent Orders of 10/05/1998 and 5/05/1994.

PATTERSON, Anthony Curtis, MD

Location: Concord, NC (Cabarrus Co)
 DOB: 5/21/1958
 License #: 0000-34429
 Specialty: P/ADP (as reported by physician)
 Medical Ed: Medical College of Georgia (1985)
 Action: 5/05/2000. Order issued lifting Consent Orders of June 5, 1998, and February 12, 1999.

STEWART-CARBALLO, Charles Willy, MD

Location: McCain, NC (Cumberland Co)
 DOB: 2/24/1957
 License #: 0000-38215
 Specialty: OBG/GP (as reported by physician)
 Medical Ed: University of Minnesota (1985)
 Action: 7/10/2000. Order issued lifting Consent Orders of 2/17/1999, 7/22/1998, 7/31/1997, 12/18/1997, and 6/28/1995.

TEMPORARY/DATED LICENSES:

ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

BREWER, Thomas Edmund, Jr, MD

Location: High Point, NC (Guilford Co)
 DOB: 11/04/1956
 License #: 0000-28141
 Specialty: GP/OM (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1983)
 Action: 7/21/2000. Temporary/dated license extended to expire 1/31/2001.

BURSON, Jana Kaye, MD

Location: Mooresville, NC (Iredell Co)
 DOB: 5/14/1961
 License #: 0000-39164
 Specialty: IM (as reported by physician)
 Medical Ed: Ohio State University (1987)
 Action: 7/21/2000. Full and unrestricted license reinstated.

COLLINS, Natalear Rolline, MD

Location: Franklinton, NC (Franklin Co)
 DOB: 10/22/1955
 License #: 0000-27108
 Specialty: GP/FP (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1981)
 Action: 5/26/2000. Full and unrestricted license reinstated.

COYNE, Mark Dennis, MD

Location: Stoney Creek, NC (Guilford Co)
 DOB: 8/12/1949
 License #: 0000-33493
 Specialty: EM/OS (as reported by physician)
 Medical Ed: Chicago Medical School (1983)
 Action: 7/21/2000. Temporary/dated license extended to expire 11/30/2000.

ENGLEMAN, James Donald, Jr, MD

Location: Vanceboro, NC (Craven Co)

DOB: 4/05/1960
 License #: 0000-32696
 Specialty: FP (as reported by physician)
 Medical Ed: University of Louisville (1985)
 Action: 5/26/2000. Full and unrestricted license reinstated.

GREGORY, Ginger Dobbins, Physician Assistant

Location: Fuquay-Varina, NC (Wake Co)
 DOB: 8/30/1963
 License #: 0001-01410
 PA Education: Bowman Gray School of Medicine (1991)
 Action: 5/26/2000. Temporary/dated license extended to expire 5/31/2001.

HARRIS, Donald Philip, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 4/09/1934
 License #: 0000-13127
 Specialty: IM (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1961)
 Action: 7/21/2000. Full and unrestricted license reinstated.

HENDRICKS, David Martin, MD

Location: Goldsboro, NC (Wayne Co)
 DOB: 5/20/1951
 License #: 2000-00454
 Specialty: AN (as reported by physician)
 Medical Ed: Medical University of South Carolina (1988)
 Action: 5/26/2000. Full and unrestricted license issued.

HOLTKAMP, John Harry, MD

Location: Raleigh, NC (Wake Co)
 DOB: 11/20/1954
 License #: 0000-28045
 Specialty: CHN/PD (as reported by physician)
 Medical Ed: New York University (1980)
 Action: 7/21/2000. Temporary/dated license extended to expire 1/31/2001.

LUTZ, Robert Paul, MD

Location: Chapel Hill, NC (Orange Co)
 DOB: 5/05/1948
 License #: 0000-27387
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1982)
 Action: 7/21/2000. Temporary/dated license extended to expire 3/31/2001.

MARTIN, Carol Ann, MD

Location: Raleigh, NC (Wake Co)
 DOB: 10/14/1952
 License #: 0099-01651
 Specialty: P (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1978)
 Action: 7/21/2000. Temporary/dated license, limited to general psychiatry and sleep disorder, extended to expire 1/31/2000.

MEAD, Robert J., MD

Location: Asheboro, NC (Randolph Co)
 DOB: 12/13/1945
 License #: 0000-32790
 Specialty: PD (as reported by physician)
 Medical Ed: Jefferson Medical College (1978)
 Action: 5/26/2000. Temporary/dated license extended to expire 11/30/2000.

PFLIEGER, Kurt Loring, MD

Location: Mount Pleasant, TX
 DOB: 5/16/1955
 License #: 2000-00113
 Specialty: EM (as reported by physician)
 Medical Ed: St George's University, Grenada (1987)
 Action: 7/21/2000. Temporary/dated license extended to 7/31/2001.

PRESSLY, Margaret Rose, MD

Location: Sylva, NC (Jackson Co)
 DOB: 5/5/1956
 License #: 0000-34548
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1990)
 Actions: 7/21/2000. Temporary/dated license, limited to Sylva Family Practice, extended to 11/30/2000.

PRESSLY, Margaret Rose, MD

Location: Sylva, NC (Jackson Co)
 DOB: 5/5/1956
 License #: 0000-34548
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1990)
 Action: 5/26/2000. Temporary/dated license extended to expire 7/31/2000. Limited to Sylva Family Practice.

SHIVE, Robert Macgregor, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 11/02/1933
 License #: 0000-13226
 Specialty: P (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1961)
 Action: 5/26/2000. Temporary/dated license extended to expire 5/31/2001.

STEWART-CARBALLO, Charles Willy, MD

Location: McCain, NC (Hoke Co)
 DOB: 2/24/1957
 License #: 0000-38215
 Specialty: OBG/GP (as reported by physician)
 Medical Ed: University of Minnesota (1985)
 Action: 5/26/2000. Full and unrestricted license reinstated.

WEST, Harold Kenneth, Jr, MD

Location: Maitland, FL
 DOB: 4/21/1954
 License #: 0098-00437
 Specialty: FP/EM (as reported by physician)
 Medical Ed: Loma Linda University (1979)
 Action: 7/21/2000. Full and unrestricted license reinstated.

WILLIAMS, David Randall, MD

Location: Hendersonville, NC (Henderson Co)
 DOB: 1/10/1950

License #: 0000-31218
 Specialty: U (as reported by physician)
 Medical Ed: University of South Alabama (1982)
 Action: 7/21/2000. Temporary/dated license issued to expire 1/31/2001.

See Consent Orders:

GALEA, Lawrence J., MD
RIDDLE, William Mark, MD
WASHINGTON, Clarence J., MD

DISMISSALS**BALOCH, Mohammad Haroon, MD**

Location: Raleigh, NC (Wake Co)
 DOB: 4/01/1947
 License #: 0000-25688
 Specialty: FP (as reported by physician)
 Medical Ed: King Edward, Pakistan (1970)
 Action: 6/03/2000. Based on the evidence presented at a hearing on 5/25/2000, the Board finds Dr Baloch did not engage in unprofessional conduct as alleged in the Board's Notice of Charges and Allegations of 9/08/1998. Therefore, the charges against Dr Baloch are dismissed with prejudice.

REES, Terry Taylor, MD

Location: Crawfordville, FL
 DOB: 7/01/1930
 License #: 0000-31896
 Specialty: GP/TS (as reported by physician)
 Medical Ed: Tulane University (1955)
 Action: 6/03/2000. Based on evidence presented to the Board at a related hearing held on 5/25/2000, it appears the charges against Dr Rees should be dismissed. Therefore, the Board's Notice of Charges and Allegations of 9/08/1998 against Dr Rees is dismissed with prejudice.

North Carolina Medical Board

Meeting Calendar, Application Deadlines, Examinations

November 2000 -- September 2001

Board Meetings are open to the public, though some portions are closed under state law.

North Carolina Medical Board November 15-18, 2000

November Meeting Deadlines:
 Nurse Practitioner Approval Applications October 2, 2000
 Physician Assistant Applications October 31, 2000
 Physician Licensure Applications October 31, 2000

North Carolina Medical Board January 24-27, 2001

January Meeting Deadlines:
 Nurse Practitioner Approval Applications December 11, 2000
 Physician Assistant Applications January 10, 2001
 Physician Licensure Applications January 9, 2001

North Carolina Medical Board March 14-17, 2001

March Meeting Deadlines:
 Nurse Practitioner Approval Applications February 5, 2001
 Physician Assistant Applications March 7, 2001
 Physician Licensure Applications February 26, 2001

North Carolina Medical Board May 16-19, 2001

May Meeting Deadlines:
 Nurse Practitioner Approval Applications April 2, 2001
 Physician Assistant Applications May 2, 2001
 Physician Licensure Applications May 1, 2001

North Carolina Medical Board July 18-21, 2001

July Meeting Deadlines:
 Nurse Practitioner Approval Applications June 4, 2001
 Physician Assistant Applications July 3, 2001
 Physician Licensure Applications July 3, 2001

North Carolina Medical Board September 19-22, 2001

September Meeting Deadlines:
 Nurse Practitioner Approval Applications August 6, 2001
 Physician Assistant Applications September 4, 2001
 Physician Licensure Applications September 4, 2001

👉 Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

The May 1999 administration of the USMLE Step 3 was the last pencil and paper administration. Computer-based testing for Step 3 became available on a daily basis in November 1999. *Applications may be obtained from the office of the North Carolina Medical Board by telephoning (919) 326-1100.* Details on administration of the examination will be included in the application packet.

Special Purpose Examination (SPEX)

The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at 400 Fuller Wiser Road, Suite 300, Euless, TX 76039 or telephone (817) 868-4000.

CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board
PO Box 20007, Raleigh, NC 27619

Please print or type.

Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

☐ Business: _____

Phone: (_____) _____ Fax: (_____) _____

☐ Home: _____

Phone: (_____) _____ Fax: (_____) _____

The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 60 days of a move.

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ELECTRONIC REGISTRATION: IT'S HERE!!!!!!

Physicians, physician assistants, and nurse practitioners who are within 60 days of their birthdays now have the opportunity to handle their annual registration with the North Carolina Medical Board via the Internet, using a valid Mastercard® or Visa® credit card. Instructions for doing this will be included on the postcard registration notice mailed to them prior to their birthdays. (The postcard will also tell them how to obtain a paper registration form if they prefer to continue registering by mail.) The Board's new electronic registration system is not only easy and simple, it offers an immediate receipt and proof of registration using a secure Internet site. Go to <http://renewal.ncmedboard.org>.

As a physician, physician assistant, or nurse practitioner, you should make note of this new registration system and ensure the Board's postcard registration notice is not misplaced when it arrives at your designated address. If others handle your mail before it reaches you, be sure they know the importance of the postcard registration notice. And remember, register only once, either via the Internet OR by mail – not both.

North Carolina Medical Board
P.O. Box 20007
Raleigh, NC 27619